



Medicaid EHR Incentive Program

# Eligible Hospital Meaningful Use Attestation Manual

October 1, 2013  
Version 1.3



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## Record Of Changes

<u>Changed Section</u>	<u>Description</u>	<u>Updated by</u>	<u>Update Date</u>	<u>Release</u>
<u>9.2</u>	<u>Added a home page</u>	<u>EHR Team</u>	<u>5/22/2012</u>	<u>1.25</u>
<u>9.3</u>	<u>Updated the CMS/NLR screen</u>	<u>EHR Team</u>	<u>5/22/2012</u>	<u>1.25</u>
<u>3.1</u> <u>4</u>	<u>Included "preceding" 12 months</u> <u>Expanded definition to include Title XXI-CHIP (but not separate</u> <u>CHIP encounters</u>	<u>TLT</u>	<u>1/18/2012</u>	<u>1</u>
<u>6</u> <u>7</u> <u>11</u>	<u>Links updated</u>	<u>TLT</u>	<u>1/18/2012</u>	
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<u>11.4</u>	<u>Preceding 12 months drop down menu screen added</u> <u>Verbage included in explanation</u>	<u>TLT</u>	<u>1/18/2012</u>	
<u>11.5</u>	<u>MU Questionnaire Screen Added</u>	<u>TLT</u>	<u>1/18/2012</u>	
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<u>12.2</u>	<u>Meaningful Use Core Measure 1 Screen added with functionality</u> <u>detail</u>	<u>TLT</u>	<u>1/18/2012</u>	
<u>12.3</u>	<u>Meaningful Use Core Measure 2 Screen</u>	<u>TLT</u>	<u>1/18/2012</u>	
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<u>12.11</u>	<u>Meaningful Use Core Measure 10 Screen added with functionality</u> <u>detail</u>	<u>TLT</u>	<u>1/18/2012</u>	
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<a href="#">14.1</a>	<a href="#">Meaningful Use Clinical Quality Measure 1 Screen added with functionality detail</a>	<a href="#">TLT</a>	<a href="#">1/18/2012</a>	
<a href="#">14.2</a>	<a href="#">Meaningful Use Clinical Quality Measure 2 Screen added with functionality detail</a>	<a href="#">TLT</a>	<a href="#">1/18/2012</a>	
<a href="#">14.3</a>	<a href="#">Meaningful Use Clinical Quality Measure 3 Screen added with functionality detail</a>	<a href="#">TLT</a>	<a href="#">1/18/2012</a>	
<a href="#">14.4</a>	<a href="#">Meaningful Use Clinical Quality Measure 4 Screen added with functionality detail</a>	<a href="#">TLT</a>	<a href="#">1/18/2012</a>	
<a href="#">14.5</a>	<a href="#">Meaningful Use Clinical Quality Measure 5 Screen added with functionality detail</a>	<a href="#">TLT</a>	<a href="#">1/18/2012</a>	
<a href="#">14.6</a>	<a href="#">Meaningful Use Clinical Quality Measure 6 Screen added with functionality detail</a>	<a href="#">TLT</a>	<a href="#">1/18/2012</a>	
<a href="#">14.7</a>	<a href="#">Meaningful Use Clinical Quality Measure 7 Screen added with functionality detail</a>	<a href="#">TLT</a>	<a href="#">1/18/2012</a>	
<a href="#">14.8</a>	<a href="#">Meaningful Use Clinical Quality Measure 8 Screen added with functionality detail</a>	<a href="#">TLT</a>	<a href="#">1/18/2012</a>	
<a href="#">14.9</a>	<a href="#">Meaningful Use Clinical Quality Measure 9 Screen added with functionality detail</a>	<a href="#">TLT</a>	<a href="#">1/18/2012</a>	
<a href="#">14.10</a>	<a href="#">Meaningful Use Clinical Quality Measure 10 Screen added with functionality detail</a>	<a href="#">TLT</a>	<a href="#">1/18/2012</a>	
<a href="#">14.11</a>	<a href="#">Meaningful Use Clinical Quality Measure 11 Screen added with functionality detail</a>	<a href="#">TLT</a>	<a href="#">1/18/2012</a>	
<a href="#">14.12</a>	<a href="#">Meaningful Use Clinical Quality Measure 12 Screen added with functionality detail</a>	<a href="#">TLT</a>	<a href="#">1/18/2012</a>	
<a href="#">14.13</a>	<a href="#">Meaningful Use Clinical Quality Measure 13 Screen added with functionality detail</a>	<a href="#">TLT</a>	<a href="#">1/18/2012</a>	
<a href="#">14.14</a>	<a href="#">Meaningful Use Clinical Quality Measure 14 Screen added with functionality detail</a>	<a href="#">TLT</a>	<a href="#">1/18/2012</a>	
<a href="#">14.15</a>	<a href="#">Meaningful Use Clinical Quality Measure 15 Screen added with functionality detail</a>	<a href="#">TLT</a>	<a href="#">1/18/2012</a>	
<a href="#">15</a>	<a href="#">Summary of Measures Screen added with functionality detail</a>	<a href="#">TLT</a>	<a href="#">1/18/2012</a>	
<a href="#">15.1</a>	<a href="#">Summary of Meaningful Use Core Measures Screen added with functionality detail</a>	<a href="#">TLT</a>	<a href="#">1/18/2012</a>	
<a href="#">15.2</a>	<a href="#">Summary of Clinical Quality Measures Screen added with functionality detail</a>	<a href="#">TLT</a>	<a href="#">1/18/2012</a>	
<a href="#">15.3</a>	<a href="#">Summary of Meaningful Use Menu Measures Screen added with functionality detail</a>	<a href="#">TLT</a>	<a href="#">1/18/2012</a>	
<a href="#">16</a>	<a href="#">Incentive Payment Calculations Screen Added with functionality detail</a>	<a href="#">TLT</a>	<a href="#">1/18/2012</a>	
<a href="#">16.1</a>	<a href="#">Incentive Payment Calculations Document Upload Screen Added with functionality detail</a>	<a href="#">TLT</a>	<a href="#">1/18/2012</a>	
<a href="#">17</a>	<a href="#">Attestation Statement Screen Added with functionality detail</a>	<a href="#">TLT</a>	<a href="#">1/18/2012</a>	
<a href="#">18</a>	<a href="#">Issues/Concerns Screen Added with functionality detailed</a>	<a href="#">TLT</a>	<a href="#">1/18/2012</a>	
<a href="#">19</a>	<a href="#">Appeals Screen added with functionality detailed</a>	<a href="#">TLT</a>	<a href="#">1/18/2012</a>	
<a href="#">19.1</a>	<a href="#">Audit Appeals and Functionality added with functionality detailed</a>	<a href="#">TLT</a>	<a href="#">1/18/2012</a>	
<a href="#">19.1.1</a>	<a href="#">Audit Appeals Details screen appeals Setup Tab added with functionality detailed</a>	<a href="#">TLT</a>	<a href="#">1/18/2012</a>	
<a href="#">19.1.2</a>	<a href="#">Findings Tab Added with functionality detailed</a>	<a href="#">TLT</a>	<a href="#">1/18/2012</a>	
<a href="#">19.1.3</a>	<a href="#">Document Upload Tab with functionality detailed</a>	<a href="#">TLT</a>	<a href="#">1/18/2012</a>	
<a href="#">19.1.4</a>	<a href="#">Outcome Tab Added with functionality detailed</a>	<a href="#">TLT</a>	<a href="#">1/18/2012</a>	
<a href="#">19.2</a>	<a href="#">Attestation Appeals Added</a>	<a href="#">TLT</a>	<a href="#">1/18/2012</a>	
<a href="#">20</a>	<a href="#">Further Information on Meaningful Use Link updated</a>	<a href="#">TLT</a>	<a href="#">1/18/2012</a>	
9.4	Added the word "consecutive" to the patient volume information and added 3(i) (ii) (iii), as well as 17 (i) (ii) (iii)	TA	10/1/2013	
10.49	The number sequence was incorrectly listed as "10.80". I corrected it to "10.49"	TA	10/1/2013	
10.50	The number sequence was incorrectly listed as "10.81". I corrected it to "10.50"	TA	10/1/2013	

# 1 INTRODUCTION

The Kentucky Medicaid EHR Incentive Program provides incentive payments to eligible professionals as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. The purpose of this document is to provide instructions for eligible hospitals, CAHs, or eligible professionals to register for and complete attestation for the Kentucky Medicaid EHR Incentive Program using the KYSLR system.

## Resources:

- 42 CFR Parts 412, 413, 422 et al. Medicare and Medicaid Programs; Electronic Health Record Incentive Program Final Rule located at <http://www.gpo.gov/fdsys/pkg/FR-2010-07-28/pdf/2010-17207.pdf>
- Kentucky State Medicaid HIT Plan (SMHP) Version 3.0 located at [http://chfs.ky.gov/NR/rdonlyres/1158A0F3-B33E-44F5-B774-6A7B9D53D493/0/KY\\_SMHP\\_v3\\_10072011.pdf](http://chfs.ky.gov/NR/rdonlyres/1158A0F3-B33E-44F5-B774-6A7B9D53D493/0/KY_SMHP_v3_10072011.pdf)
- Kentucky Medicaid EHR Application Portal located at <https://prd.chfs.ky.gov/kyslr/>
- Medicare and Medicaid Electronic Health records (EHR) Incentive Program located at <http://www.cms.gov/EHRIncentivePrograms/>
- Office of the National Coordinator for Health Information Technology located at [http://healthit.hhs.gov/portal/server.pt/community/healthit\\_hhs\\_gov\\_\\_home/1204](http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__home/1204)

Regional Extension Centers (RECs) have been designated to provide technical assistance to Kentucky EH and CAHs. The RECs that provide a full range of assistance related to EHR selection and training are listed below:

- **Northern/Northeastern Kentucky – Tri-State REC**  
Website: <http://www.healthbridge.org/rec>  
Phone: 513-469-7222 Option 3 or 4  
E-mail: [info@healthbridge.org](mailto:info@healthbridge.org)
- **Northeast Kentucky – Northeast Kentucky Regional Information Organization (NeKY RHIO)**  
Website: <http://www.nekyrhio.org/nekyrhio/>  
Phone: 855-385-2081 or 206-824-0481  
E-mail: [admin@nekyrhio.org](mailto:admin@nekyrhio.org)
- **Rest of Kentucky – Kentucky REC**  
Website: <http://www.ky-rec.org/>  
Phone: 888-KY-REC-EHR or 859-323-3090  
E-mail: [kyrec@uky.edu](mailto:kyrec@uky.edu)

If you would like more information on the measures required for Meaningful Use please see the site below:

[http://www.cms.gov/EHRIncentivePrograms/30\\_Meaningful\\_Use.asp#TopOfPage](http://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp#TopOfPage)

**Revisions**

Original 12/17/2011

Revised 3/26/2012

Revised 4/1/2013

Revised 10/1/2013

## 2 BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) has implemented, through provisions of the American Recovery and Reinvestment Act of 2009 (ARRA), incentive payments to eligible professionals (EP) and eligible hospitals (EH), including critical access hospitals (CAHs), participating in Medicare and Medicaid programs that are meaningful users of certified Electronic Health Records (EHR) technology. The incentive payments are not a reimbursement, but are intended to encourage EPs and EHs to adopt, implement, or upgrade certified EHR technology and use it in a meaningful manner.

Use of certified EHR systems is required to qualify for incentive payments. The Office of the National Coordinator for Health Information Technology (ONC) has issued rules defining certified EHR systems and has identified entities that may certify systems. More information about this process is available at <http://www.healthit.hhs.gov>.

Goals for the national program include: 1) enhance care coordination and patient safety; 2) reduce paperwork and improve efficiencies; 3) facilitate electronic information sharing across providers, payers, and state lines and 4) enable data sharing using state Health Information Exchange (HIE) and the National Health Information Network (NHIN). Achieving these goals will improve health outcomes, facilitate access, simplify care and reduce costs of health care nationwide.

The Kentucky Department for Medicaid Services (DMS) works closely with federal and state partners to ensure the Kentucky Medicaid EHR Incentive Program fits into the overall strategic plan for the Kentucky Health Information Exchange (KHIE), thereby advancing national and Kentucky goals for HIE.

Both EPs and EHs are required to begin by registering at the national level with the Medicare and Medicaid registration and attestation system (also referred to as the NLR). CMS' official Web site for the Medicare and Medicaid EHR Incentive Programs can be found at <http://www.cms.gov/EHRIncentivePrograms/>. The site provides general and detailed information on the programs, including tabs to guide users on the path to payment, eligibility, meaningful use, certified EHR technology, and frequently asked questions.



### 3 ELIGIBILITY

While EHs can begin the program in Calendar Year (CY) 2013, they must begin the program no later than Federal Fiscal year (FFY) 2016.

The first tier of provider eligibility for the Kentucky Medicaid EHR Incentive Program is based on provider type and specialty. If the provider type and specialty for the submitting provider in the KY MMIS provider data store does not correspond to the provider types and specialties approved for participation in the Kentucky Medicaid EHR Incentive Program, the provider will receive an error message with a disqualification statement.

At this time, CHFS DMS has determined that the following hospitals are potentially eligible to enroll in the Kentucky Medicaid EHR Incentive Program:

- Acute Care Hospital = Any provider with a Provider Type 01 and Specialty 010
- Children's Hospital = Any provider with a Provider Type 01 and Specialty 015
- CAH = Any provider with a Provider Type 01 and Specialty 014

#### Additional requirements for the EH/CAH

To qualify for an EHR incentive payment for each year the EH seeks the incentive payment, the EH must be one of the following:

1. An acute care hospital (includes CAH) that has at least a 10 percent Medicaid patient volume for each year the hospital seeks an EHR incentive payment or
2. A children's hospital (exempt from meeting a patient volume threshold).

Hospital-based providers are not eligible for the EHR incentive program.

**Qualifying Providers by Type and Patient Volume**

Program Entity	Percent Patient Volume over Minimum 90-days
Acute Care Hospital	10%
Children's Hospital	Patient Encounter definition expanded to include TXXI-CHIP encounters (but not separate CHIPs)

#### 3.1 Out-of-State Eligible Hospitals/CAHs

The Kentucky Medicaid EHR Incentive Program welcomes any out-of-state Eligible Hospital/CAH to participate in this program as long as they have at least one physical location in Kentucky. Kentucky must be the only state they are requesting an incentive payment from during that participation year. For audit purposes, out-of-state Eligible Hospitals/CAHs must make available any and all records, claims data, and other data pertinent to an audit by either the Kentucky DMS program or CMS. Records must be maintained as applicable by law in the state of practice or Kentucky, whichever is deemed longer.

## 3.2 Establishing Patient Volume

An eligible provider must annually meet patient volume requirements to participate in Kentucky's Medicaid EHR Incentive Program as established through the state's CMS approved State Medicaid Health IT Plan (SMHP). The patient funding source identifies who can be counted in the patient volume: Title XIX (TXIX) – Medicaid and Title XXI (TXXI) – CHIP (but not separate CHIPs). All EH and CAHs should calculate patient volume based on TXIX - Medicaid and/or TXXI-CHIP and out-of-state Medicaid patients.

### 3.2.1 Patient Encounters Methodology

- EHs - To calculate TXIX DMS patient volumeThe total TXIX DMS and out-of-state Medicaid encounters in any representative 90-day period in the preceding fiscal year OR the preceding 12 months by:
  - ✓ The total encounters in the same 90-day period.
  - ✓ Total number of inpatient bed days for all discharges in a 90-day period (even if some of those days preceded the 90-day range) plus total number of emergency department visits in the same 90-day period. *(Please note per CMS FAQ nursery days are excluded from inpatient bed days)*
  - ✓ An emergency department must be part of the hospital.

### Eligible Hospital DMS Encounter Definition

For purposes of calculating eligible hospital patient volume, a DMS encounter is defined as services rendered to an individual 1) per inpatient discharge, or 2) on any one day in the emergency room where TXIX and TXXI-CHIP DMS (but not separate CHIPs) or another state's Medicaid program paid for :

- Part or all of the service;
- Part or all of their premiums, co-payments, and/or cost-sharing;

## 4 PAYMENT METHODOLOGY FOR ELIGIBLE HOSPITALS

Statutory parameters placed on Kentucky Medicaid incentive payments to hospitals are largely based on the methodology applied to Medicare incentive payments. The specifications described in this section are limits to which all states must adhere when developing aggregate EHR hospital incentive amounts for Medicaid-eligible hospitals. States will calculate hospital aggregate EHR hospital incentive amounts on the FFY to align with hospitals participating in the Medicare EHR incentive program.

Children's hospitals and acute care hospitals may be paid up to 100 percent of an aggregate EHR hospital incentive amount provided over a three-year period. Section 1905(t)(5)(D) requires that no payments can be made to hospitals after 2016 unless the provider has been paid a payment in the previous year; thus, while Medicaid EPs are afforded flexibility to receive payments on a non-consecutive, annual basis, hospitals receiving a Medicaid incentive payment must receive payments on a consecutive, annual basis after the year 2016. The aggregate EHR hospital incentive amount is calculated using an overall EHR amount multiplied by the Medicaid share.

Kentucky is responsible for using auditable data sources to calculate Medicaid aggregate EHR hospital incentive amounts, as well as determining Kentucky Medicaid incentive payments to those providers. Auditable data sources include:

- Providers' Medicare cost reports;
- State-specific Medicaid cost reports;
- Payment and utilization information from the Kentucky MMIS (or other automated claims processing systems or information retrieval systems); and
- Hospital financial statements and hospital accounting records.

The Kentucky Medicaid EHR Incentive Program hospital aggregate incentive amount calculation will use the equation outlined in the proposed rule, as follows:

$$\text{EH Payment} = \text{Overall EHR Amount} \times \text{Medicaid Share}$$

Where: \_\_\_\_\_

**Overall EHR Amount** = {Sum over 4 year of [(Base Amount plus Discharge Related Amount Applicable for Each Year) times Transition Factor Applicable for Each Year]}

**Medicaid Share** = {(Medicaid inpatient-bed-days + Medicaid managed care inpatient-bed-days) divided by [(total inpatient-bed days) times (estimated total charges minus charity care charges) divided by (estimated total charges)]}

Kentucky intends to pay the aggregate hospital incentive payment amount over a period of three annual payments, contingent on the hospital's annual attestations and registrations for the annual Kentucky Medicaid payments. The reason for this approach is that most of Kentucky's numerous rural hospitals operate on a very thin margin and need the money as soon as possible to offset their EHR system costs.

In the first year, if all conditions for payment are met, 50 percent of the aggregate amount will be paid to the EH. In the second year, if all conditions for payment are met, 40 percent of the aggregate amount will be paid to the EH. In the third year, if all conditions for payment are met, 10 percent of the aggregate amount will be paid to the EH.

Kentucky has worked with CMS on ways to effectively calculate costs. For example, charity care costs are not included on Kentucky's cost report. Kentucky has received approval from CMS to use the Kentucky Medical Assistance Program (KMAP) disproportionate share form data in lieu of cost reports for this data. A standard questionnaire is used to determine the disproportionate share.

To the extent there is simply not sufficient data that would allow us to estimate the inpatient bed-days attributable to Medicaid managed care patients, the statute directs that such figure is deemed to equal 0. Likewise, if there is simply not sufficient data for the state to estimate the percentage of inpatient bed days that are not charity care (that is,  $[\text{estimated total charges} - \text{charity care charges}] / \text{estimated total charges}$ ), the statute directs that such figure is deemed to equal 1. Unlike Medicaid EPs, who must waive rights to duplicative Medicare incentive payments, hospitals may receive incentive payments from both Medicare and Medicaid, contingent on successful demonstration of meaningful use and other requirements under both programs.

The last year that a hospital may begin receiving Medicaid incentive payments is FY 2016. States must make payments over a minimum of three years. Additionally, in any given payment year, no annual Medicaid incentive payment to a hospital may exceed 50 percent of the hospital's aggregate incentive payment. Likewise, over a two-year period, no Medicaid payment to a hospital may exceed 90 percent of the aggregate incentive.

## 5 PROVIDER REGISTRATION

If this is your second year with the EHR incentive program, then there is no need to register with CMS. You may log in directly to the KYSLR to attest for Meaningful Use using the link <http://chfs.ky.gov/dms/ehr.htm>.

EHRs are required to begin by registering at the national level with the Medicare and Medicaid registration and attestation system (also referred to as the NLR). CMS' official Web site for the Medicare and Medicaid EHR Incentive Programs can be found at <http://www.cms.gov/EHRIncentivePrograms/>.

Providers must provide their name, NPI, business address, phone number, tax payer ID number (TIN) of the entity receiving the payment and hospitals must provide their CCN.

Providers must revisit the NLR to make any changes to their information and/or choices, such as changing the program from which they want to receive their incentive payment. After the initial registration, the provider does not need to return to the NLR before seeking annual payments unless information needs to be updated. EHRs seeking payment from both Medicare and Medicaid will be required to visit the NLR annually to attest to meaningful use before returning to the KYSLR system to attest for Kentucky's Medicaid EHR Incentive Program. DMS will assume meaningful use is met for hospitals deemed so for payment from the Medicare EHR Incentive Program.

The NLR will assign the provider a CMS Registration Number and electronically notify DMS of a provider's choice to access Kentucky's Medicaid EHR Incentive Program for payment. The CMS Registration Number will be needed to complete the attestation in the KYSLR system.

On receipt of NLR Registration transactions from CMS, two basic validations take place at the state level: 1) validate the NPI in the transaction is on file in the MMIS system, and 2) validate the provider is a provider with the Kentucky DMS. If either of these conditions is not met, a message will be automatically sent back to the CMS NLR indicating the provider is not eligible. Providers may check back at the NLR level to determine if the registration has been accepted.

Once payment is disbursed to the eligible TIN, NLR will be notified by DMS that a payment has been made.

## 6 PROVIDER ATTESTATION PROCESS AND VALIDATION

DMS will utilize the secure KYSLR system to house the attestation system. The link will only be visible to providers whose type in the MMIS system matches an EHR incentive eligible provider category. If an eligible provider registers at the NLR and does not receive the link to the attestation system within two business days, assistance will be available by contacting the DMS Provider Enrollment Call Center Operations at: (502) 564-5472.

The following is a description of the information that a provider will have to report or attest to during the process.

1. After registering for the incentive program with the CMS EHR Registration and Attestation National Level Repository (NLR) at <http://www.cms.gov/EHRIncentivePrograms/>, the EH will be asked provide:
  - Completed patient volume information on the KYSLR Web site;
  - Completed Hospital EHR Incentive Payment Worksheet;
  - Certification number for the ONC-ATCB certified EHR system (or numbers if obtained in modules).
2. The EH will be asked to attest to:
  - Adoption, implementation or upgrade of certified EHR technology or meaningful user;
  - Not receiving a Medicaid incentive payment from another state.
3. The EH will be asked to electronically sign the amendment;
  - The provider enters his/her initials and NPI on the Attestation Screen (there is a place for an agent or staff member of the provider to so identify); and
  - The person filling out the form should enter his or her name.

**Note:** *For providers that are ready to demonstrate Meaningful Use in year 1, the provider will attest to this fact.*

Once the electronic attestation is submitted by a qualifying provider and appropriate documentation provided, DMS will conduct a review which will include cross-checking for potential duplication payment requests, checking provider exclusion lists and verifying supporting documentation.

The attestation itself will be electronic and will require the EH to attest to meeting all requirements defined in the federal regulations. Some documentation will have to be provided to support specific elements of attestation. All providers will be required to submit supporting documentation for patient volume claimed in the attestation. More information on documentation will be provided in the attestation system.

During the first year of the program is the only time an EH will be allowed to attest to adopting, implementing or upgrading to certified EHR technology. It should be noted that the documentation for AIU of certified EHR technology for EHs does not have to be dated in the year of reporting. Documentation dated any time prior to the attestation is acceptable if the system and version of EHR technology has been certified by ONC (the Certified Health IT Product List can be located at ONC's website at <http://www.healthit.hhs.gov>). EHs can attest to either AIU or meaningful use as appropriate.

All providers will be required to attest to meeting meaningful use to receive incentive payments after attesting to the Adopt, Implement, or Upgrade for the first time.

## **7 INCENTIVE PAYMENTS**

Upon completion of the attestation process, including submission of the electronic attestation, receipt of required documentation and validation by DMS, an incentive payment can be approved. Providers will be notified of approval for payment by email to the email address submitted with registration. Please be sure that the email provided is current.

## **8 PROGRAM INTEGRITY**

DMS will be conducting regular reviews of attestations and incentive payments. These reviews will be selected as part of the current audit selection process, including risk assessment, receipt of a complaint or incorporation into reviews selected for other objectives. Providers should be sure to keep their supporting documentation.

### **8.1 Administrative Audits and Appeals**

You may appeal the determination made by the Kentucky Department for Medicaid Services on your incentive payment application. Please send a Formal Letter of Appeal to the address below, within 30 days of the determination date of notification. This formal written notification must include a detailed explanation of why the EP or EH deems a wrong determination made by the Kentucky Medicaid EHR Incentive Program. Any supporting documentation to the appeal should be included with the Letter of Appeal.

Division of Program Integrity  
Department for Medicaid Services  
275 E. Main Street, 6E-A  
Frankfort, KY 40621

## 9 GETTING STARTED

Hospitals will be required to provide details including patient volume characteristics, EHR details, growth rate and Medicaid. They will complete a Hospital EHR Incentive Payment worksheet as well as upload all requested documentation and electronically sign the attestation (more details follow in this manual). They will first register with the National Level Registry (NLR) at <http://www.cms.gov/EHRIncentivePrograms/>. This registration is only needed once, if this is your second year of the EHR Incentive Program then you may go directly to the KYSLR sight shown below.

The hospital provider then begins the Kentucky Medicaid EHR Incentive Program registration process by accessing the KYSLR system at <http://chfs.ky.gov/dms/ehr.htm> (sign-in screen shown below) and entering the NPI and CMS-assigned registration identifier that was received from CMS.

### 9.1 Eligible Hospital Sign-in Screen

The provider will enter the NPI registered on the NLR and the CMS-assigned Registration Identifier that was returned by the NLR. Please allow 48 hours from registration to log into the KYSLR. The EH will only need to register once, if you are a returning provider you will be able to log in at any time.

If the data submitted by the provider matches the data received from the NLR, the CMS/NLR Provider Demographics Screen will display with the pre-populated data received from the NLR. If the provider entry does not match, an error message with instructions will be returned.



## 9.2 Eligible Hospital Home Screen

The Home screen will give the EH data about their current KY Attestation as well as provide navigation for the EH to view a previous attestation or begin/modify a new attestation for their next EHR Incentive payment.

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**KENTUCKY**  
CABINET FOR HEALTH AND FAMILY SERVICES  
KY MEDICAID EHR INCENTIVE PAYMENTS

Home (Year 3 Attestation)

Home  
Reports  
View All Payment Years  
Issues/Concerns  
Appeals  
Additional Resources  
User Manual  
Send E-mail

**Announcements And Messages**  
No Announcements and Messages !

**Issues/Concerns**  
Clicking the below link will redirect you to the Issues/Concerns page, where you will be able to submit any issues and view the responses recieved from the DMS.  
[Click Here](#)

**Provider Information**  
You are currently enrolled in KY's EHR Incentive Program.  
Payment Year '3' is your current year attestation.  
The current status of your application for the year 3 payment is 'AWAITING PROVIDER ATTESTATION'.

**Stage of Meaningful Use**

1st Year	2011	2012	2013	2014	2015	2016
2011	AIU 1	MU Stage 1 (90 Days)	MU Stage 1 (365 Days)	N/A	N/A	N/A

**Provider Status Flow**

```

graph LR
    A[CMS Registration] --> B[Preliminary Verification]
    B --> C[Provider Attestation]
    B --- D[Completed]
    C --- E[In Process]
  
```

**Provider Attestations**

Payment Year	Status	AttestationID	Action
1	Paid	KY0001220	<a href="#">View</a>
2	Paid	KY0001223	<a href="#">View</a>
3	Attest_inProcess	-	<a href="#">Begin/Modify Attestation</a>

There are six sections to the Home page listed below:

1. **Announcements and Messages** – This will be the first section on the page if a message or announcement exists for the provider.
2. **Issues/Concerns** – This will be the second section on the page. The Issues / Concerns will provide a link for the provider to redirect to the Issues / Concerns page if he would like to submit a new issue or view a response to an issue.
3. **Provider Information** – This is the third section of the home page. The provider information will give the high level status for the provider, the current payment year and the current status for the payment year.
4. **Stage of Meaningful Use** – This is the fourth section of the home page. This grid will supply which stage of Meaningful Use you will need to attest to according to the program year you are attesting.
5. **Provider Status Flow** – this is the fourth section of the home page. The Provider Status Flow will give a diagram showing the provider where he is in the current year's attestation. If the provider has been found not eligible for any reason, he will also find the specific reasons for that finding in this section.
6. **Provider Attestations** – this is the fifth section of the home page. The Provider Attestation table will list the providers attestations by payment year and list the navigation actions he has available for each.

## 9.3 Registration Data Screen

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**KENTUCKY**  
CABINET FOR HEALTH AND FAMILY SERVICES  
KY MEDICAID EHR INCENTIVE PAYMENTS

Registration Data (Year 3 Attestation)

Home  
Reports  
View All Payment Years  
Issues/Concerns  
Appeals  
Additional Resources  
User Manual  
Send E-mail

**Provider CMS Registration Data**

\*\*\* If any of this information is incorrect, please correct on the [CMS Registration Module](#)

Applicant National Provider Index (NPI):	0111111111	Name:	Test demo Hospital
Applicant TIN:	0111111111	Suffix:	
Payee National Provider Index(NPI):		Address :	123 Test , Test
Payee TIN:		City/State:	Test / KY
Program Option:	MEDICAID	Zip Code:	40601 -8838
Medicaid State:	KY	Phone Number:	1234567890
Provider Type:	Medicare_Advantage_Hospitals	Email:	Carla.Mitchell@ky.gov
Participation Year:	3	Specialty:	CRITICAL ACCESS HOSPITAL
Federal Exclusions:	None	State Rejection Reason:	None

**Provider Medicaid Attestation Data**

\*\*\* Please update the data below in reference to this attestation

**Mailing Address**

Address 1: 123 Test

Address 2: Test

City / State: Test KY

Zip Code: 40601 8838

Were you assisted by a Regional Extension Center in Kentucky? ☒ Yes ☐ No

Please give the name of the person who assisted you: Carla

Previous Next Save Cancel

Along with the pre-populated data from the CMS Registration Module there are additional fields that can be updated by the provider.

The data provided by the CMS Registration Module is view only. If any of this data is incorrect then the data must be updated by logging in to the CMS Registration Module, making the updates and re-submission of the registration. Please allow 24 hours for the changes to be reflected in the screen above. The fields that are from the CMS registration are listed below:

- **Applicant National Provider Index (NPI)** – This is the eligible hospital or CAH’s registering NPI. The NPI registered at CMS should be the same NPI that is enrolled in KY Medicaid.
- **Applicant TIN** – This is the Tax Identification Number that was listed in the CMS registration. This TIN should be the same TIN that is listed for the provider under KY Medicaid.
- **Payee National Provider Index (NPI)** – This is the payee NPI given during the CMS registration.
- **Payee TIN** – The tax identification number associated with the payee NPI.
- **Program Option** – This is the program option that was selected by the provider during their registration. It will be Medicaid if you are attesting with a State Agency and not Medicare.

- **Medicaid State** – This is the State that was selected during the provider’s registration.
- **Provider Type** – This is the provider type that was given during the registration at CMS.
- **Participation year** – This is the provider’s participation year with the EHR Incentive Program
- **Federal Exclusion** – This will list any federal exclusion found on the provider if any during registration with CMS.
- **Name** – The Provider’s name listed on the CMS Registration
- **Address 1** – The provider’s street address listed on the CMS registration
- **Address 2** – The provider’s street address listed on the CMS registration
- **City/State** – The provider’s city/state listed on the CMS registration
- **Zip Code** – The provider’s zip code listed on the CMS registration
- **Phone Number** – The provider’s phone number given on the CMS registration. This number is used for contact by EHR staff reviewing the attestations.
- **Email** – The provider’s email given during the CMS registration. This email address is used for system generated emails on updates for the provider’s attestation and communication from the EHR review staff.
- **Specialty** – The provider’s specialty listed in the CMS registration.
- **State Rejection Reason** – This lists the state rejection reason if any are found. This will only list federal codes for rejection, for a more detailed state specific rejection see the home page.

The data listed under the section **Provider Medicaid Attestation Data** is updatable by the provider during attestation. Once the attestation is submitted by the provider the data will become view only. Those data fields are described below:

- **Medicaid ID** - This field only displays if you have multiple Kentucky Medicaid Provider Numbers that are linked to the Payee NPI listed in your CMS registration. If so, you will need to select one of your Kentucky Medicaid Numbers. **This Medicaid Number will be used to for your incentive payments.**
- **Mailing Address** - The mailing address can be updated if the provider would like to give an alternate address from the one listed from CMS for correspondence. Indicating a new address in these fields will change the Payee address for the Provider’s EHR incentive payment.
- **Were you assisted by a Kentucky Regional Extension Center** - Response to this question is required. If the response is yes, then please type the name of the person who assisted you during the attestation process.

## 9.4 Hospital Eligibility Details Screen

Eligible Hospitals must enter four categories of data to complete the Eligibility Details screen including patient volume characteristics, EHR details, growth rate, and Medicaid share. Hospitals will see the following data on the screen:

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 CABINET FOR HEALTH AND FAMILY SERVICES  
 KY MEDICAID EHR INCENTIVE PAYMENTS

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Hospital Eligibility Details (Year 3 Attestation)

All \* fields are required fields.

Home  
Reports  
View All Payment Years  
Issues/Concerns  
Appeals  
Additional Resources  
User Manual  
Send E-mail

Patient Volume	1. For which program year are you applying?	* 2013
	What is the time frame used for patient volume calculation?	* Prior Fiscal Year
	2. Select the starting date of the 90-day period(in the prior FFY) to calculate Medicaid patient volume percentage:	* 7/1/2012 (mm/dd/yy)
	3.(i) Medicaid Inpatient Discharges during this period:	* 80
	(ii) Medicaid ER/other Discharges (requires attestation):	* 80
	(iii) Total Medicaid patient discharges during this period:	* 160
	4. Total patient discharges during this period:	* 222
	5. Medicaid patient volume percentage:	72.07%
EHR Details:	6. Enter the CMS EHR Certification ID of your EHR:	* 30000001TFCPEAK <a href="#">What is this?</a>
	7. Indicate the status of your EHR:	* <input checked="" type="radio"/> Meaningful User
	Due to special circumstances does your Cost report information need to be adjusted?	* <input checked="" type="radio"/> Yes <input type="radio"/> No
	Please select the cost report you are using?	* Form CMS 2552-96
Growth Rate:	8. Select the end date of the hospital's most recently filed 12-month cost reporting period:	* 3/4/2010 (mm/dd/yy)
	9. Total number of discharges that fiscal year:	* 234 (w/s S-3, Part I, Col. 15, Line 12)
	10. Total number of discharges one year prior:	* 333
	11. Total number of discharges two years prior:	* 345
	12. Total number of discharges three years prior:	* 4555
Medicaid Share:	13. Total Medicaid inpatient bed days (Exclude Nursery beds):	* 9000 (w/s S-3, Part I, Col. 5, Line 1 + Lines 6-10)
	14. Total Medicaid HMO inpatient bed days (Exclude Nursery beds):	* 9388 (w/s S-3, Part I, Col. 5, Line 2)
	15. Total inpatient bed days:	* 155000
	16. Total hospital charges:	* 209.00 (w/s C, Part I, Col. 8, Line 101)
	17.(i) Inpatient Uncompensated Care Charges:	* 0.00 (KMAP-4, Line 4)
	(ii) Non-Inpatient Uncompensated Care Charges:	* 0.00 (Upload signed supporting documentation)
	(iii) Total uncompensated care charges:	* 0.00

Previous

Next

Save

Cancel

## Patient Volume

1. Select the program year you wish to attest.
  - This should be either the preceding 12 months OR it can be the prior Federal Fiscal year if the current date is between 10/1 – 12/31.
2. Starting date of the consecutive 90-day period to calculate Medicaid patient volume percentage
  - This date should be a consecutive 90-day period within the Federal Fiscal Year OR the preceding 12 months prior to the program year selected above.
3. (i) Medicaid Inpatient discharges during this period  
 (ii) Medicaid ER/other discharges during this period  
 (iii) Auto-caluculation of (i) and (ii)
4. Total patient discharges during the period
5. Medicaid patient volume percentage (auto-calculated)

## EHR details

6. EHR certification ID of EHR
7. Status of your EHR – Choices:
  - (A) Adopt - Acquire, purchase, or secure access to certified EHR technology
  - (I) Implement - Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements
  - (U) Upgrade - Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the ONC EHR certification criteria
  - Meaningful User - currently meaningfully using certified EHR technology and are prepared to attest to Meaningful Use and Clinical Quality Measures.

## Growth rate

- *After* attestation Year 2 and forward: Due to special circumstances does your cost report information need to be adjusted – This should only be yes if the data used to calculate your original payment included nursery or swing bed days or you have been working with the Hospital Division due to another issue and requested that you update this information.
- Select the Cost Report you are using. (ie. Form CMS 2552-96)
8. End date of the hospital's most recently filed 12-month cost reporting period
  9. Total number of discharges that fiscal year
    - On the cost report documents this will be w/s S-3 part I, col. 15, line 14
  10. Total number of discharges one year prior
  11. Total number of discharges two years prior
  12. Total number of discharges three years prior

**Medicaid share**

## 13. Total Medicaid inpatient bed days

- On the cost report documents this will be w/s S-3 part I, col. 7, line 14 and per CMS FAQ 10668 (FAQ 3315) should not include nursery/swing bed days

## 14. Total Medicaid Health Maintenance Organization (HMO) inpatient bed days

- On the cost report documents this will be w/s S-3 part I, col. 7, line

## 15. Total inpatient bed days

- On the cost report documents this will be w/s S-3 part I, col. 8, line

## 16. Total hospital charges

- On the cost report documents this will be w/s c part I, col. 8 line 202

## 17. (i) Inpatient uncompensated care charges

(ii) Non-Inpatient uncompensated care charges

(iii) Total uncompensated care charges (auto-calculated)

## 9.5 Meaningful Use Questionnaire Screen

After entering the provider eligibility details, EHs who have selected Meaningful Use will be directed to the Meaningful Use Questionnaire screen.

**Note:** if you are registered as a dual eligible hospital you must complete your MU attestation with Medicare prior to entering your attestation with Medicaid.

The following fields are required to continue with the attestation:

1. **Enter EHR Reporting Period Start Date** – This is the starting date for the period of time you are reporting your Meaningful Use Measure data.
  - If you are attesting as a dual eligible hospital then this date should be the same date as the one that was attested for your Medicare Meaningful Use attestation. The system will locate the file from Medicare from this date and you will not be requested to re-enter those measures already submitted to Medicare
2. **Enter EHR Reporting Period End Date** – This is the end date for the period of time you are reporting your Meaningful Use Measure data.
  - If you are attesting as a dual eligible hospital then this date should be the same date as the one that was attested for your Medicare Meaningful Use attestation. The system will locate the file from Medicare from this date and you will not be requested to re-enter those measures already submitted to Medicare
3. **Enter the percentage of unique patients who have structured data recorded in your certified EHR technology as of the reporting period above.**
  - This should be the percentage of all the patients you have seen in service location(s) with Certified EHR Technology who have data recorded in your EHR.
    - This can be calculated by dividing the number of patients with structured data in your Certified EHR by the total number of patients seen at service location(s) with Certified EHR Technology. Multiply by 100 to obtain the percentage. The amount of patients with structured data stored in your EHR should be at least 80%.
4. **Emergency Department (ED) Admissions** - Indicate the method that designates how patients admitted to the ED will be included in the denominators of certain Meaningful Use Core and Menu Measures.



## 10 REQUIREMENTS FOR MEANINGFUL USE MEASURES FOR EHS

12 out of 12 Core Meaningful Use measures must be met according to the CMS threshold.

- Exception – If CMS allows exclusion to a measure and the EH attests to that exclusion then that measure is still considered completed

5 out of 10 Menu Measures must be met according to the CMS threshold (including exclusions) and At least 1 of the 5 Menu Measures met by the EH must be from the Public Health List.

- Exception - If an EH meets the criteria for and can claim exclusion for both of the public health menu measures, the EH must still select one public health menu measure and attest that the EH qualifies for the exclusion. \*\*This exclusion will count toward the 5 required menu measures. In Kentucky the Immunization Registry is available through KHIE.
- EH must select the remaining 4 that relate to his/her practice, if exclusion applies to one of the measures selected the EH has to attest that the other measures did not relate to his practice or they also would have been exclusions.
- CMS encourages eligible hospitals to select menu measures on which they can report and to claim an exclusion for a menu measure only in cases where there are no remaining menu measures for which they can qualify or if there are no remaining menu measures on which they are able to support

EH must attest to 15 of 15 Clinical Quality Measures

- CMS has expanded the definition of a Meaningful User of certified EHR technology. EHs beyond their first year must report 15 out of 15 CQMs this has been removed as an objective from previous years and is now mandatory
  - No patients in the measure population; It is acceptable to report zero in the denominator, even for 1 or more measures, as long as that is the value displayed & calculated by the certified EHR. The EH attests to this fact.
  - Beginning in 2014 the automated reporting of the clinical quality measures will be accomplished using certified EHR technology interoperable with the systems designated by CMS to receive the data for the Medicare until then CQMs for Medicaid will continue to be submitted through the attestation process until otherwise specified by the State.

For additional information on Meaningful Use Measures Please see the following CMS Web site below:  
[http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful\\_Use.html](http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html)

**Measure Screen Tip:** If the page seems to be cutting off words on the measure then do the following steps:

- While holding down the 'Ctrl' key press the '-' key until you can see the entire screen.



## 10.1 Meaningful Use Measure Menu Screen

The menu screen will only allow the user to select a group of measures as they are available. For Example once the Meaningful Use Core Measures are completed, the Meaningful Use Menu Measures will be active to select.

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**KENTUCKY**  
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KY Medicaid EHR Incentive Program (Year 3 Attestation)

Home  
Reports  
Meaningful Use Questionnaire  
Meaningful Use Menu Options  
Meaningful Use Core Measures  
Meaningful Use Menu Measures  
Clinical Quality Measures  
Pre-Attestation Measure Summary  
View All Payment Years  
Issues/Concerns  
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Additional Resources  
User Manual  
Send E-mail

Please select a menu option below:

[Meaningful Use Core Measures](#)

[Meaningful Use Menu Measures](#)

[Clinical Quality Measures](#)

Previous Next

### Navigation:

**Meaningful Use Core Measures Link** – Takes the EH to the first screen of the Meaningful Use Core Measures, active link.

**Meaningful Use Menu Measures Link** - Takes the EH to the first screen of the Meaningful Use Menu Measures, only active after the MU Core Measures are completed.

**Core Clinical Quality Measures Link** – Takes the EH to the first screen of the Core Clinical Quality Measures, only active after the MU Menu Measures are completed.

## 10.2 Meaningful Use Core Measure 1 Screen

### Medication List and Medication Orders

Please select from one of measures:

- More than 30% of all unique patients with at least one medication in their medication list seen by the EH have at least one medication order entered using CPOE.
- More than 30% of medication orders created by the EH during the EHR reporting period are recorded using CPOE.

ALL patient records not just those maintained using certified EHR technology.  
 from patient records maintained using certified EHR technology.  
 on:  
 ients in the denominat  
 ue patients with at least  
 period.

**select a measure**

☐ More than 30% of all unique patients with at least one medication in their medication list admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one medication order entered using CPOE.

☒ More than 30% of medication orders created by the authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE

**Save** **Continue**

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All fields must be completed unless the exclusion was responded to with 'Yes'. In that case, no other field is required and the EH should be allowed to save and continue to the next measure. If the exclusion is not selected, the following details other requirements of this screen:

- The Numerator and Denominator must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- EH must meet the >30% threshold, N/D > 30%.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

## 10.2.1 First Alternate Measure Screen

Depending on your selection, all fields must be completed before the EH can proceed to the next measure.

Meaningful Use Core Measures - (Year 3 Attestation)

Questionnaire 1 of 12

(\* ) Red asterisk indicates a required field.  
If you need to change the measure selection click 'previous' button and navigate to this screen by clicking 'Next'.

Objective: Use Computerized Provider Order Entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.

Measure: More than 30% of all unique patients with at least one medication in their medication list admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one medication order entered using CPOE.

\* PATIENT RECORDS: Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

☐ This data was extracted from ALL patient records not just those maintained using certified EHR technology.

☐ This data was extracted only from patient records maintained using certified EHR technology.

Complete the following information:

Numerator = The number of patients in the denominator that have at least one medication order entered using CPOE.

Denominator = Number of unique patients with at least one medication in their medication list seen by the eligible hospital or CAH during the EHR reporting period.

\* Numerator:  \* Denominator:

Previous Next Save Cancel

The following details other requirements of this screen:

- The Numerator and Denominator are required and must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- The EH must meet the >30% threshold,  $N/D > 30\%$ .

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

## 10.2.2 Second Alternate Measure Screen

Depending on your selection, all fields must be completed before the EH can proceed to the next measure.

Meaningful Use Core Measures - (Year 3 Attestation)

Questionnaire 1 of 12

(\* ) Red asterisk indicates a required field.  
If you need to change the measure selection click 'previous' button and navigate to this screen by clicking 'Next'.

Objective: Use Computerized Provider Order Entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.

Measure: More than 30% of medication orders created by the authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.

\* PATIENT RECORDS: Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

☒ This data was extracted from ALL patient records not just those maintained using certified EHR technology.

☐ This data was extracted only from patient records maintained using certified EHR technology.

Complete the following information:

Numerator = The number of patients in the denominator that have at least one medication order entered using CPOE.

Denominator = Number of unique patients with at least one medication in their medication list seen by the eligible hospital or CAH during the EHR reporting period.

\* Numerator: 1008 \* Denominator: 1208

Previous Next Save Cancel

The following details other requirements of this screen:

- The Numerator and Denominator are required and must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- The EH must meet the >30% threshold,  $N/D > 30\%$ .

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

### 10.3 Meaningful Use Core Measure 2 Screen

#### Drug-Drug and Drug - Allergy Interaction

Questionnaire 2 is for the implementation of drug-drug interaction check. The provider is prompted with the question, "Have you enabled the functionality for drug-drug interaction checks for the entire EHR reporting period?" Please select Yes or No to continue to the next screen.

Meaningful Use Core Measures (Year 3 Attestation)

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Appeals  
Additional Resources  
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Send E-mail

**Questionnaire 2 of 12**

(\*) Red asterisk indicates a required field.

Objective: Implement drug-drug and drug-allergy interaction checks

Measure: The eligible hospital or CAH has enabled this functionality for the entire EHR reporting period.

Complete the following information:

\* Have you enabled the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period?

☒ Yes ☐ No

Previous Next Save Cancel

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next' will also save data entered on the screen.

## 10.4 Meaningful Use Core Measure 3 Screen

### Maintain Up-to-date Problem List of Current and Active Diagnoses

All fields must be completed before the EH is allowed to save and continue to the next measure.

Meaningful Use Core Measures (Year 3 Attestation)

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Meaningful Use Core Measures  
Clinical Quality Measures  
Pre-Attestation Measure Summary  
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Issues/Concerns  
Appeals  
Additional Resources  
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Send E-mail

**Questionnaire 3 of 12**

(\*) Red asterisk indicates a required field.

Objective: Maintain an up-to-date problem list of current and active diagnoses.

Measure: More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as structured data.

Complete the following information:

**Numerator** = Number of patients in the denominator who have at least one entry or an indication that no problems are known for the patient recorded as structured data in their problem list.

**Denominator** = Number of unique patients admitted to an eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

\* Numerator : 2      \* Denominator : 2

\* Enter the number of patients in the numerator above that have the entry of no problems indicated as their structured data.

2

Previous    Next    Save    Cancel

The following details other requirements of this screen:

- The Numerator and Denominator are required and must be a whole number
- The Numerator should be less than or equal to the Denominator
- The EH must meet the >80% threshold,  $N/D > 80\%$
- The EH must enter an answer on the last question on the page, if the count is unknown then type unknown as the answer.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next' will also save data entered on the screen.

## 10.5 Meaningful Use Core Measure 4 Screen

### Maintain Active Medication List

All fields must be completed before the EH is allowed to save and continue to the next measure.

Meaningful Use Core Measures (Year 3 Attestation)

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Meaningful Use Core Measures  
Meaningful Use Menu Measures  
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Pre-Attestation Measure Summary  
View All Payment Years  
Issues/Concerns  
Appeals  
Additional Resources  
User Manual  
Send E-mail

Questionnaire 4 of 12

(\*) Red asterisk indicates a required field.

Objective: Maintain active medication list.

Measure: More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.

Complete the following information:

**Numerator** = Number of patients in the denominator who have a medication (or an indication that the patient is not currently prescribed any medication) recorded as structured data.  
**Denominator** = Number of unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

\* Numerator :3      \* Denominator :3

\* Enter the number of unique patients listed within the numerator above as patients that are not currently prescribed any medication as structured data :3

Previous    Next    Save    Cancel

The following details other requirements of this screen:

- The Numerator and Denominator are required and must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- The EH must meet the >80% threshold, N/D > 80%.
- The EH must enter an answer on the last question on the page, if the count is unknown then type unknown as the answer

Please note that selecting 'Previous' before saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

## 10.6 Meaningful Use Core Measure 5 Screen

### Maintain Active Medication Allergy List

All fields must be completed before the EH is allowed to save and continue to the next measure.

Meaningful Use Core Measures - (Year 3 Attestation)

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**Questionnaire 5 of 12**

(\*) Red asterisk indicates a required field.

Objective: Maintain active medication allergy list.

Measure: More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.

Complete the following information:

**Numerator** = Number of unique patients in the denominator who have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data in their medication allergy list.

**Denominator** = Number of unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

\* Numerator 4 \* Denominator 4

\* Enter the unique number of patients included in the numerator that had an indication of no known allergies recorded as their structured data 4

Previous Next Save Cancel

The following details other requirements of this screen:

- The Numerator and Denominator are required and must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- The EH must meet the >80% threshold,  $N/D > 80\%$ .
- The EH must enter an answer on the last question on the page, if the count is unknown then type unknown as the answer.

Please note that selecting 'Previous' before saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

## 10.7 Meaningful Use Core Measure 6 Screen

### Record Demographics

All fields must be completed before the EH is allowed to save and continue to the next measure.

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### Questionnaire 6 of 12

**(\*) Red asterisk indicates a required field.**

Objective: Record all of the following demographics:

- Preferred language
- Gender
- Race
- Ethnicity
- Date of birth
- And preliminary cause of death in the event of mortality in the hospital or CAH.

Measure: More than 50% of all unique patients seen by the eligible hospital or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data.

Complete the following information:

**Numerator** = Number of patients in the denominator who have all the elements of demographics (or a specific exclusion if the patient declined to provide one or more elements or if recording an element is contrary to state law) recorded as structured data.

**Denominator** = Number of unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

\* Numerator :       \* Denominator :

\* Enter the count from the numerator (if any) of unique patients that had most but not all of the demographic information recorded as structured data due to the exclusion listed in the instructions :

Previous
Next
Save
Cancel

The following details other requirements of this screen:

- The Numerator and Denominator are required and must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- The EH must meet the >50% threshold, N/D > 50%.
- The EH must enter an answer on the last question on the page, if the count is unknown then type unknown as the answer.

Please note that selecting 'Previous' before saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.



## 10.8 Meaningful Use Core Measure 7 Screen

### Height Weight and Blood Pressure

Please select one of the following two measures:

- More than 50% of all unique patients age 2 and over seen by the EH or CAH, height, weight and blood pressure are recorded as structure data. This selection contains 2 exclusions.
- More than 50% of all unique patients seen by the EH or CAHs during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight for all ages. This selection contains 4 exclusions.

☒ For more than 50% of all unique patients age 2 and over admitted to eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23), height, weight and blood pressure are recorded as structure data.

☐ More than 50% of all unique patients admitted by the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structure data.

Continue

**\* PATIENT RECORDS:** Please select only from patient records maintained in the EHR system

☒ This data was extracted from patient records maintained in the EHR system

☐ This data was extracted from other sources

**Numerator** = Number of patients in the denominator who have at least one entry of their height, weight and blood pressure are recorded as structured data.

The following details other requirements of this screen:

- The Numerator and Denominator are required and must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- The EH must meet the >50% threshold,  $N/D > 50\%$ .

## 10.8.1 First Alternate Measure Screen

Depending on your selection, all fields must be completed before the EH is allowed to save and continue to the next measure.

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**Questionnaire 7 of 12**

(\*) Red asterisk indicates a required field.  
If you need to change the measure selection click 'previous' button and navigate to this screen by clicking 'Next'.

Objective: Record and chart changes in vital signs:

- Height
- Weight
- Blood pressure
- Calculate and display body mass index (BMI)
- Plot and display growth charts for children 2-20 years, including BMI.

Measure: For more than 50% of all unique patients age 2 and over admitted to eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23), height, weight and blood pressure are recorded as structure data.

\* **PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

☐ This data was extracted from ALL patient records not just those maintained using certified EHR technology.

☒ This data was extracted only from patient records maintained using certified EHR technology.

Complete the following information:

**Numerator** = Number of patients in the denominator who have at least one entry of their height, weight and blood pressure are recorded as structured data.

**Denominator** = Number of unique patients age 2 or over that is admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

\* Numerator: 50      \* Denominator: 100

Previous   Next   Save   Cancel

The following details other requirements of this screen:

- The Numerator and Denominator are required and must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- The EH must meet the >50% threshold,  $N/D > 50\%$ .

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

## 10.8.2 Second Alternate Measure Screen

Depending on your selection, all fields must be completed before the EH is allowed to save and continue to the next measure.

Meaningful Use Core Measures (Year 3 Attestation)

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Questionnaire 7 of 12

(\*) Red asterisk indicates a required field.  
If you need to change the measure selection click 'previous' button and navigate to this screen by clicking 'Next'.

Objective: Record and chart changes in vital signs:

- Height
- Weight
- Blood pressure
- Calculate and display body mass index (BMI)
- Plot and display growth charts for children 2-20 years, including BMI.

Measure: More than 50% of all unique patients admitted by the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structure data.

**\* PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

☐ This data was extracted from ALL patient records not just those maintained using certified EHR technology.

☒ This data was extracted only from patient records maintained using certified EHR technology.

Complete the following information:

**Numerator** = Number of patients in the denominator who have at least one entry of their height, weight and blood pressure are recorded as structured data.

**Denominator** = Number of unique patients age 2 or over that is admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

**\* Numerator** : 7 **\* Denominator** : 7

Previous
Next
Save
Cancel

The following details other requirements of this screen:

- The Numerator and Denominator are required and must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- The EH must meet the >50% threshold,  $N/D > 50\%$ .

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

## 10.9 Meaningful Use Core Measure 8 Screen

### Record Smoking Status

All fields must be completed unless the exclusion was responded to with 'Yes'. In that case, no other field is required and the EH should be allowed to save and continue to the next measure.

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Questionnaire 8 of 12

(\*) Red asterisk indicates a required field.

Objective: Record smoking status for patients 13 years old or older

Measure: More than 50% of all unique patients 13 years old or older admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data.

**EXCLUSION: Based on All Patient Records:** An eligible hospital or CAH that sees no patients 13 years or older would be excluded from this requirement. Exclusion from this requirement does not prevent an eligible hospital or CAH from achieving meaningful use.

\* Does this exclusion apply to you?

☐ Yes ☒ No

Complete the following information:

**Numerator** = Number of patients in the denominator with smoking status recorded as structured data.  
**Denominator** = Number of unique patients age 13 or older admitted to the eligible hospital's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

\* Numerator :7      \* Denominator :7

Previous

Next

Save

Cancel

The following details other requirements of this screen:

- The Numerator and Denominator are required and must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- The EH must meet the >50% threshold,  $N/D > 50\%$ .

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

## 10.10 Meaningful Use Core Measure 9 Screen

### Clinical Decision Support

All fields must be completed before the EH will be allowed to save and continue to the next measure.

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**Questionnaire 9 of 12**

(\*) Red asterisk indicates a required field.

Objective: Implement one clinical decision support rule related to a high priority hospital condition along with the ability to track compliance to that rule.

Measure: Implement one clinical decision support rule  
Complete the following information:

\* Did you implement one clinical decision support rule?  
☒ Yes ☐ No

\* Enter a CDS rule that was implemented: 1

Previous Next Save Cancel

The following details other requirements of this screen:

- The EH must answer yes or no to the first question on the page.
- The EH must enter the core clinical decision support rule that was implemented. If the response is unknown, then type unknown as the answer.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

## 10.11 Meaningful Use Core Measure 10 Screen

### Patient Provided with a Copy of Health Information

All fields must be completed unless the exclusion was responded to with 'Yes'. In that case, no other field is required and the EH should be allowed to save and continue to the next measure.

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**Questionnaire 10 of 12**

(\*) Red asterisk indicates a required field.

**Objective:** Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, discharge summary, procedures), upon request.

**Measure:** More than 50% of all patients of the inpatient or emergency department of the eligible hospital or CAH (POS 21 or 23) who request an electronic copy of their health information are provided it within 3 business days.

**\* PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

☐ This data was extracted from ALL patient records not just those maintained using certified EHR technology.

☒ This data was extracted only from patient records maintained using certified EHR technology.

**EXCLUSION: Based on All Patient Records:** An eligible hospital or CAH that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an eligible hospital or CAH from achieving meaningful use.

**\* Does this exclusion apply to you?**

☐ Yes ☒ No

Complete the following information:

**Numerator =** Number of patients in the denominator who receive an electronic copy of their electronic health information within three business days.

**Denominator =** Number of patients of the eligible hospital or CAH who request an electronic copy of their electronic health information four business days prior to the end of the EHR reporting period.

**\* Numerator**  **\* Denominator**

Previous Next Save Cancel

The following details other requirements of this screen:

- The Numerator and Denominator are required and must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- The EH must meet the >50% threshold, N/D > 50%.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

## 10.12 Meaningful Use Core Measure 11 Screen

### Clinical Summaries for Patient

All fields must be completed unless the exclusion was responded to with 'Yes'. In that case, no other field is required and the EH should be allowed to save and continue to the next measure.

Meaningful Use Core Measures (Year 3 Attestation)

Questionnaire 11 of 12

(\*) Red asterisk indicates a required field.

Objective: Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request.

Measure: More than 50% of all patients who are discharged from an eligible hospital or CAH's inpatient department or emergency department (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided it.

\* PATIENT RECORDS: Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

☐ This data was extracted from ALL patient records not just those maintained using certified EHR technology.

☒ This data was extracted only from patient records maintained using certified EHR technology.

EXCLUSION: Based on All Patient Records: An eligible hospital or CAH that has no requests from patients or their agents for an electronic copy of their discharge instructions during the EHR reporting period they would be excluded from this requirement. Exclusion from this requirement does not prevent an eligible hospital or CAH from achieving meaningful use.

\* Does this exclusion apply to you?

☐ Yes ☒ No

Complete the following information:

Numerator = The number of patients in the denominator who are provided an electronic copy of discharge instructions.

Denominator = Number of patients discharged from an eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) who request an electronic copy of their discharge instructions during the EHR reporting period.

\* Numerator:  \* Denominator:

Previous Next Save Cancel

The following details other requirements of this screen:

- The Numerator and Denominator are required and must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- The EH must meet the >50% threshold,  $N/D > 50\%$ .

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

## 10.13 Meaningful Use Core Measure 12 Screen

### Protect Electronic Health Information

All fields must be completed before the EH will be allowed to save and continue to the next measure.

Meaningful Use Core Measures (Year 3 Attestation)

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**Questionnaire 12 of 12**

(\*) Red asterisk indicates a required field.

Objective: Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.

Measure: Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.

Complete the following information:

\* Did you conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process?

☒ Yes ☐ No

Previous Next Save Cancel

The following details other requirements of this screen:

- A response must be submitted.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next' will also save data entered on the screen.



## 10.14 Meaningful Use Menu Measures Selection Screen

A total of 5 Menu Measures must be selected for the EH to continue to the next screen. At least one of these measures must be from the Public Health Measure list. The EH must choose a measure that they would meet unless an exclusion can be claimed for both measures. In Kentucky, the Immunization Registry, Syndromic Surveillance, Cancer Registry and Reportable Labs are available through KHIE.

Meaningful Use Menu Measures (Year 3 Attestation)

**Navigation:**  
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 SURE 2.0.00

**Questionnaire**

**Instructions:**

Eligible hospitals must report on a total of five (5) Meaningful Use Menu Measures. At least one of the five measures must be from the public health menu measures. Should the eligible hospital be able to successfully meet only one of these public health menu measures, the eligible hospital must select and report on that measure to CMS. Meeting just one public health menu measure, the eligible hospital must then select any other four menu measures from the Meaningful Use Menu Measures. In selecting the remaining four measures, the eligible hospital may select any combination from the remaining public health menu measures or from the additional Meaningful Use Menu Measures in the list below.

If an eligible hospital meets the criteria for and can claim an exclusion for all of the public health menu measures, they must still select one public health menu measure and attest that they qualify for the exclusion. They must then select any other four measures from the menu measures, which can be any combination from the remaining public health menu measures or from the additional Meaningful Use Menu Measures in the list below. CMS encourages eligible hospitals to select menu measures on which they can report and to claim an exclusion for a menu measure only in cases where there are no remaining menu measures for which they qualify or if there are no remaining menu measures on which they are able to report.

You must select at least one Meaningful Use Menu Measure from the public health list even if an exclusion is applied:

Select	Description	Measure
<input checked="" type="checkbox"/>	Capability to submit electronic data to immunization registries or immunization information systems and actual submission in accordance with applicable law and practice except where prohibited.	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow-up submission if the test is successful (unless none of the immunization registries to which the eligible hospital or CAH submits such information has the capacity to receive the information electronically).
<input checked="" type="checkbox"/>	Capability to submit electronic data on reportable lab required by state or local law to public health agencies and actual submission in accordance with applicable law and practice except where prohibited.	Performed at least one test of certified EHR technology's capacity to provide electronic submission of reportable lab results to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which eligible hospital or CAH submits such information have the capacity to receive the information electronically).

You must submit additional menu measure objectives until a total of five Meaningful Use Menu Measure Objectives have been selected, even if an exclusion applies to all of the menu measure objectives that are selected (total of five includes the public health menu measure objectives):

Select	Objective	Measure
<input checked="" type="checkbox"/>	Implement drug-formulary checks.	The eligible hospital or CAH has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.
<input checked="" type="checkbox"/>	Record advance directives for patients 65 years old or older.	More than 50% of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) or 23) during the EHR reporting period have an indication of an advance directive status recorded as structured data.
<input checked="" type="checkbox"/>	Incorporate clinical lab test results into EHR as structured data.	More than 40% of all clinical lab test results ordered by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period without results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.
<input checked="" type="checkbox"/>	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, or outreach.	Generate at least one report listing patients of the eligible hospital or CAH with a specific condition.
<input type="checkbox"/>	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.	More than 35 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are provided patient-specific education resources.
<input type="checkbox"/>	The eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	The eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is admitted to the eligible hospital or CAH's inpatient or emergency department (POS 21 or 23).
<input type="checkbox"/>	The eligible hospital or CAH that transferred their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral.	The eligible hospital or CAH that transfers or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals.

**Navigation:**  
 Previous Next Save Cancel

### Navigation:

**Logout Button** – Returns the EH to the login page.

**Previous button** – Will not save the data selected and return the EH to the MU Core Measure 15 screen.

**Next button** – Will save the data to the database if no errors are present. This data will be updatable until the attestation has been completed by the EH. The EH will be directed to the first MU Menu Measure screen they selected after all errors are resolved.

## 10.15 Meaningful Use Menu Measure 1 Screen (Public Health)

### Immunization Registry Option

All fields must be completed unless the exclusion was responded to with 'Yes', in that case no other field is required and the EH should be allowed to save and continue to the next measure.

Meaningful Use Menu Measures (Year 3 Attestation)

Home  
Reports  
Meaningful Use Questionnaire  
Meaningful Use Menu Options  
Meaningful Use Core Measures  
Meaningful Use Menu Measures  
Clinical Quality Measures  
Pre-Attestation Measure Summary  
View All Payment Years  
Issues/Concerns  
Appeals  
Additional Resources  
User Manual  
Send E-mail

**Questionnaire 1 of 5**

(\*)Red asterik indicates a required field.

Objective: Capability to submit electronic data to immunization registries or immunization information systems and actual submission in accordance with applicable law and practice except where prohibited.

Measure: Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the eligible hospital or CAH submits such information has the capacity to receive the information electronically).

**EXCLUSION 1 - Based on All Patient Records:** An eligible hospital or CAH that does not perform immunizations during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an eligible hospital or CAH from achieving meaningful use.

\*Does this exclusion apply to you?  
☐ Yes ☒ No

**EXCLUSION 2 - Based on All Patient Records:** If there is no immunization registry that has the capacity to receive the information electronically, then the eligible hospital or CAH would be excluded from this requirement. Exclusion from this requirement does not prevent an eligible hospital or CAH from achieving meaningful use.

\*Does this exclusion apply to you?  
☐ Yes ☒ No

Complete the following information:

\*Did you perform at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test was successful (unless none of the immunization registries to which the eligible hospital or CAH submits such information has the capacity to receive the information electronically)?  
☒ Yes ☐ No

\*Has a follow up test been submitted?  
☐ Yes ☒ No

\*What was the result of the test?  
☐ Successful ☒ Failed

Please Note: Neither a failed test nor failure to follow-up a test submission will prevent a provider from meeting Meaningful Use.

Previous
Next
Save
Cancel

The following details other requirements of this screen:

- Exclusion response is required.
- Response of yes or no is required if exclusion 1 and 2 has not been marked as yes.
- The EH must enter answers the last two questions on the page, if response is yes. Selecting that the test failed or failure to send a follow-up submission will not prevent a provider from meeting Meaningful Use.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

## 10.16 Meaningful Use Menu Measure 2 Screen (Public Health)

### Syndromic Surveillance Option

All fields must be completed unless the exclusion was responded to with 'Yes'. In that case, no other field is required and the EH should be allowed to save and continue to the next measure.

Meaningful Use Menu Measures (Year 3 Attestation)

Home  
Reports  
Meaningful Use Questionnaire  
Meaningful Use Menu Options  
Meaningful Use Core Measures  
Meaningful Use Menu Measures  
Clinical Quality Measures  
Pre-Attestation Measure Summary  
View All Payment Years  
Issues/Concerns  
Appeals  
Additional Resources  
User Manual  
Send E-mail

Questionnaire 1 of 5

(\*)Red asterik indicates a required field.

Objective: Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice except where prohibited.

Measure: Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an eligible hospital or CAH submits such information have the capacity to receive the information electronically).

**EXCLUSION - Based on All Patient Records:** If no public health agency to which the eligible hospital or CAH submits such information has the capacity to receive the information electronically, then the eligible hospital or CAH would be excluded from this requirement. Exclusion from this requirement does not prevent an eligible hospital or CAH from achieving meaningful use.

\* Does this exclusion apply to you?

☐ Yes ☒ No

Complete the following information:

\*Did you perform at least one test of certified EHR technologys capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test was successful (unless none of the public health agencies to which an eligible hospital or CAH submits such information have the capacity to receive the information electronically)?

☒ Yes ☐ No

\*Has a follow up test been submitted?

☒ Yes ☐ No

\*What was the result of the test?

☒ Successful ☐ Failed

Please Note: Neither a failed test nor failure to follow-up a test submission will prevent a provider from meeting Meaningful Use.

Previous

Next

Save

Cancel

The following details other requirements of this screen:

- Exclusion response required.
- Response of yes or no required if exclusion 1 and 2 has not been marked as yes.
- The EH must enter answer the last two questions on the page, if response is yes. Selecting that the test failed or failure to send a follow-up submission will not prevent a provider from meeting Meaningful Use.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next,' data entered on the screen will also be saved.

## 10.17 Meaningful Use Menu Measure 3 Screen

### Implement Drug Formulary Checks

All fields must be completed unless the exclusion was responded to with 'Yes'. In that case, no other field is required and the EH should be allowed to save and continue to the next measure.

The screenshot shows a web-based questionnaire interface. At the top, a dark blue header bar contains the text 'Meaningful Use Menu Measures (Year 3 Attestation)'. On the left side, there is a vertical navigation menu with links: Home, Reports, Meaningful Use Questionnaire, Meaningful Use Menu Options, Meaningful Use Core Measures, Meaningful Use Menu Measures (highlighted), Clinical Quality Measures, Pre-Attestation Measure Summary, View All Payment Years, Issues/Concerns, Appeals, Additional Resources, User Manual, and Send E-mail. The main content area is titled 'Questionnaire 2 of 5' and includes a note: '(\*)Red asterik indicates a required field.' Below this, the 'Objective' is 'Implement drug-formulary checks.' and the 'Measure' is 'The eligible hospital or CAH has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.' A red asterisk is placed before the text '\* PATIENT RECORDS: Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.' There are two radio button options: 'This data was extracted from ALL patient records not just those maintained using certified EHR technology.' (unselected) and 'This data was extracted by only from patient records maintained using certified EHR technology.' (selected). Another red asterisk is placed before the text '\* Did you enable the drug-formulary check functionality and did you have access to at least one internal or external drug formulary for the entire EHR reporting period?' with two radio button options: 'Yes' (selected) and 'No' (unselected). At the bottom of the form, there are four buttons: 'Previous', 'Next', 'Save', and 'Cancel'.

The following details other requirements of this screen:

- Exclusion Response is required.
- Response to last question is required.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen is also saved.

## 10.18 Meaningful Use Menu Measure 4 Screen

### Record Advance Directives

All fields must be completed unless the exclusion was responded to with 'Yes'. In that case, no other field is required and the EH should be allowed to save and continue to the next measure.

Meaningful Use Menu Measures (Year 3 Attestation)

Home  
Reports  
Meaningful Use Questionnaire  
Meaningful Use Menu Options  
Meaningful Use Core Measures  
Meaningful Use Menu Measures  
Clinical Quality Measures  
Pre-Attestation Measure Summary  
View All Payment Years  
Issues/Concerns  
Appeals  
Additional Resources  
User Manual  
Send E-mail

Questionnaire 3 of 5

(\*) Red asterisk indicates a required field.

Objective: Record advance directives for patients 65 years old or older.

Measure: More than 50% of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) have an indication of an advance directive status recorded as structured data.

\* PATIENT RECORDS: Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

☐ This data was extracted from ALL patient records not just those maintained using certified EHR technology.

☒ This data was extracted only from patient records maintained using certified EHR technology.

**EXCLUSION: Based on All Patient Records:** An eligible hospital or CAH that admitted no patients 65 years old or older during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an eligible hospital or CAH from achieving meaningful use.

\* Does this exclusion apply to you?

☐ Yes ☒ No

Complete the following information:

**Numerator** = Number of patients in the denominator with an indication of an advanced directive entered using structured data.  
**Denominator** = Number of unique patients age 65 or older admitted to an eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period.

\* Numerator 7      \* Denominator 7

Previous

Next

Save

Cancel

The following details other requirements of this screen:

- Exclusion Response is required.
- The Numerator and Denominator are required and must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- The EH must meet the >50% threshold, N/D > 50%.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

## 10.19 Meaningful Use Menu Measure 5 Screen

### Incorporate Clinical Lab-Test Results into EHR as Structured Data

All fields must be completed unless the exclusion was responded to with 'Yes'. In that case, no other field is required and the EH should be allowed to save and continue to the next measure.

Meaningful Use Menu Measures (Year 3 Attestation)

Home  
Reports  
Meaningful Use Questionnaire  
Meaningful Use Menu Options  
Meaningful Use Core Measures  
Meaningful Use Menu Measures  
Clinical Quality Measures  
Pre-Attestation Measure Summary  
View All Payment Years  
Issues/Concerns  
Appeals  
Additional Resources  
User Manual  
Send E-mail

**Questionnaire 4 of 5**

(\*) Red asterisk indicates a required field.

**Objective:** Incorporate clinical lab-test results into EHR as structured data.

**Measure:** More than 40% of all clinical lab tests results ordered by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.

\* **PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

☐ This data was extracted from ALL patient records not just those maintained using certified EHR technology.

☒ This data was extracted only from patient records maintained using certified EHR technology.

Complete the following information:

**Numerator** = Number of lab test results whose results expressed in positive or negative affirmation or as a number which are incorporated as structured data.

**Denominator** = Number of unique patients age 65 or older admitted to an eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period.

\* Numerator  \* Denominator

Previous Next Save Cancel

The following details other requirements of this screen:

- The numerator and denominator should be a whole number.
- The numerator should be less than or equal to the denominator.
- If not excluded, the EH must meet the >40% threshold, N/D > 40%.
- If an EH responds Yes to the exclusion then they have met the measure threshold.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

## 10.20 Meaningful Use Menu Measure 6 Screen

### Generate Lists of Patients by Specific Conditions

All fields must be completed unless the exclusion was responded to with 'Yes'. In that case, no other field is required and the EH should be allowed to save and continue to the next measure.

Meaningful Use Menu Measures (Year 3 Attestation)

Home  
Reports  
Meaningful Use Questionnaire  
Meaningful Use Menu Options  
Meaningful Use Core Measures  
Meaningful Use Menu Measures  
Clinical Quality Measures  
Pre-Attestation Measure Summary  
View All Payment Years  
Issues/Concerns  
Appeals  
Additional Resources  
User Manual  
Send E-mail

**Questionnaire 5 of 5**

(\*)Red asterik indicates a required field.

Objective: Generate lists of patients by specific conditions to use for quality improvements, reduction of disparities, or outreach.

Measure: Generate at least one report listing patients of the eligible hospital or CAH with a specific condition.

\* **PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

☐ This data was extracted from ALL patient records not just those maintained using certified EHR technology.

☒ This data was extracted by only from patient records maintained using certified EHR technology.

Complete the following information:

\* Did you generate at least one report listing patients of the eligible hospital or CAH with a specific condition?

☒ Yes ☐ No

\*Name at least one specific condition for which a list was created

Previous Next Save Cancel

The following details other requirements of this screen:

- Patient record response is required.
- Yes or No response is required.
- Response to last question is required.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

## 10.21 Meaningful Use Menu Measure 7 Screen

### Use CEHRT to Identify Patient Specific Resources and Provide to Patient

All fields must be completed before the EH will be allowed to save and continue to the next measure.

Meaningful Use Menu Measures (Year 3 Attestation)

Home  
Reports  
Meaningful Use Questionnaire  
Meaningful Use Menu Options  
Meaningful Use Core Measures  
Meaningful Use Menu Measures  
Clinical Quality Measures  
Pre-Attestation Measure Summary  
View All Payment Years  
Issues/Concerns  
Appeals  
Additional Resources  
User Manual  
Send E-mail

**Questionnaire 3 of 5**

(\*)Red asterik indicates a required field.

Objective:

Use certified EHR technology to identify patientspecific education resources and provide those resources to the patient if appropriate.

Measure:

More than 10 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are provided patient-specific education resources.

Complete the following information:

**Numerator** = Number of patients in the denominator who are provided patient education specific resources.

**Denominator** = Number of unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

\* Numerator:20

\* Denominator:20

Previous

Next

Save

Cancel

The following details other requirements of this screen:

- The numerator and denominator should be a whole number.
- The numerator should be less than or equal to the denominator.
- The EH must meet the 10% threshold, N/D >10 %.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.



## 10.22 Meaningful Use Menu Measure 8 Screen

### Receiving EH/CAH should perform Medication Reconciliation

All fields must be completed before the EH will be allowed to save and continue to the next measure.

Meaningful Use Menu Measures (Year 3 Attestation)

Home  
Reports  
Meaningful Use Questionnaire  
Meaningful Use Menu Options  
Meaningful Use Core Measures  
Meaningful Use Menu Measures  
Clinical Quality Measures  
Pre-Attestation Measure Summary  
View All Payment Years  
Issues/Concerns  
Appeals  
Additional Resources  
User Manual  
Send E-mail

**Questionnaire 4 of 5**

(\*) Red asterisk indicates a required field.

**Objective:** The eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.

**Measure:** The eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23).

**\* PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

☒ This data was extracted from ALL patient records not just those maintained using certified EHR technology.

☐ This data was extracted only from patient records maintained using certified EHR technology.

Complete the following information:

**Numerator** = Number of transitions of care in the denominator where medication reconciliation was performed.  
**Denominator** = Number of transitions of care during the EHR reporting period for which the eligible hospital's or CAH's inpatient or emergency department (POS 21 to 23) was the receiving party of the transition.

\* Numerator  \* Denominator

Previous Next Save Cancel

The following details other requirements of this screen:

- The numerator and denominator should be a whole number.
- The numerator should be less than or equal to the denominator.
- EH must meet the >50% threshold, N/D > 50%.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

## 10.23 Meaningful Use Menu Measure 9 Screen

### Providing Summary of Care for each Transition or Referral

All fields must be completed before the EH will be allowed to save and continue to the next measure.

Meaningful Use Menu Measures (Year 3 Attestation)

Home  
Reports  
Meaningful Use Questionnaire  
Meaningful Use Menu Options  
Meaningful Use Core Measures  
Meaningful Use Menu Measures  
Clinical Quality Measures  
Pre-Attestation Measure Summary  
View All Payment Years  
Issues/Concerns  
Appeals  
Additional Resources  
User Manual  
Send E-mail

**Questionnaire 5 of 5**

(\*) Red asterisk indicates a required field.

**Objective:** The eligible hospital or CAH that transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral.

**Measure:** The eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals.

**\* PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

☒ This data was extracted from ALL patient records not just those maintained using certified EHR technology.

☐ This data was extracted only from patient records maintained using certified EHR technology.

Complete the following information:

**Numerator** = Number of transitions of care and referrals in the denominator where a summary of care record was provided.  
**Denominator** = Number of transitions of care and referrals during the EHR reporting period for which the eligible hospital's or CAH's inpatient or emergency department (POS 21 to 23) was the transferring or referring provider.

\* Numerator  \* Denominator

Previous Next Save Cancel

The following details other requirements of this screen:

- The numerator and denominator should be a whole number.
- The numerator should be less than or equal to the denominator.
- EH must meet the >50% threshold, N/D > 50%.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

## 10.24 Core Clinical Quality Measure 1 Screen

### Emergency Department Throughput - admitted patients Median time from ED arrival to ED departure for admitted patients

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your certified EHR reporting for the EHR reporting period even if the report states zero.

**Clinical Quality Measures (Year 3 Attestation)**

**Questionnaire 1 of 15**

**Measure:** NQF 0495, Emergency Department (EDI-1)

**Title:** Emergency Department Throughput - admitted patients Median time from ED arrival to ED departure for admitted patients

**Description:** Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department.

**ED-1.1:** All ED patients admitted to the facility from the ED.  
**Denominator:** = All ED patients admitted to the facility from the ED. A positive whole number.  
**Numerator:** = Median time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the ED. A positive whole number.  
**Exclusion:** = Observation & Mental Health Patients. A positive whole number.

\* Numerator:  \* Denominator:  \* Exclusion:

**ED-1.2:** Observation ED patient stratification  
**Denominator:** = ED Observation patients admitted to the facility from the ED. A positive whole number.  
**Numerator:** = Median time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the ED. A positive whole number.

\* Numerator:  \* Denominator:

**ED-1.3:** Dx stratification ED patients  
**Denominator:** = ED patients with a Dx of Psychiatric or Mental Health Disorder admitted to the facility from the ED. A positive whole number.  
**Numerator:** = Median time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the ED. A positive whole number.

\* Numerator:  \* Denominator:

**Navigation:** Previous Next Save Cancel

The following details other requirements of this screen:

- Please enter a numerator, 0 is acceptable if that was reported by the EHR technology.
- Numerator must be a whole number.
- Please enter a denominator, 0 is acceptable if there is no measure population.
- Denominator must be a whole number.
- The numerator should be less than or equal to the denominator.
- Exclusion must be a whole number.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

## 10.25 Core Clinical Quality Measure 2 Screen

### Emergency Department Throughput - admitted patients Admission decision time to ED departure time for admitted patients

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your certified EHR reporting for the EHR reporting period even if the report states zero.

**Clinical Quality Measures (Year 3 Attestation)**

**Questionnaire 2 of 15**

**Measure:** NQF 0497, Emergency Department (ED)-2

**Title:** Emergency Department Throughput - admitted patients Admission decision time to ED departure time for admitted patients

**Description:** Median time from admit decision time to time of departure from the emergency department of emergency department patients admitted to inpatient status.

**ED-2.1: All ED patients admitted to inpatient status**  
**Denominator:** All ED patients admitted to the facility from the ED. A positive whole number.  
**Numerator:** Median time (in minutes) from admit decision time to time of departure from the ED for patients admitted to inpatient status. A positive whole number where  $N \leq D$  or  $N = 0$ .  
**Exclusion:** Observation & Mental Health Patients. A positive whole number.  
 \* Numerator: 2 \* Denominator: 2 \* Exclusion: 2

**ED-2.2: Observation ED patient stratification**  
**Denominator:** ED Observation patients admitted to the facility from the ED. A positive whole number.  
**Numerator:** Median time (in minutes) from admit decision time to time of departure from the ED for patients admitted to inpatient status. A positive whole number where  $N \leq D$  or  $N = 0$ .  
 \* Numerator: 2 \* Denominator: 2

**ED-2.3: Dx stratification ED patients**  
**Denominator:** ED patients with a Principal Dx of Psychiatric or mental health disorder admitted to the facility from the ED. A positive whole number.  
**Numerator:** Median time (in minutes) from admit decision time to time of departure from the ED for patients admitted to inpatient status. A positive whole number where  $N \leq D$  or  $N = 0$ .  
 \* Numerator: 2 \* Denominator: 2

**Navigation:** Previous Next Save Cancel

The following details other requirements of this screen:

- Please enter a numerator, 0 is acceptable if that was reported by the EHR technology.
- Numerator must be a whole number.
- Please enter a denominator, 0 is acceptable if there is no measure population.
- Denominator must be a whole number.
- The numerator should be less than or equal to the denominator.
- Exclusion must be a whole number.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

## 10.26 Core Clinical Quality Measure 3 Screen

### Ischemic stroke : Discharge on anti-thrombotics

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your certified EHR reporting for the EHR reporting period even if the report states zero.

Clinical Quality Measures (Year 3 Attestation)

Home  
Reports  
Meaningful Use Questionnaire  
Meaningful Use Menu Options  
Meaningful Use Core Measures  
Meaningful Use Menu Measures  
Clinical Quality Measures  
Pre-Attestation Measure Summary  
View All Payment Years  
Issues/Concerns  
Appeals  
Additional Resources  
User Manual  
Send E-mail

**Questionnaire 3 of 15**

(\*) Red asterisk indicates a required field.

NQF 0435, Stroke-2

Title: Ischemic stroke : Discharge on anti-thrombotics

Denominator = a positive whole number

Numerator = a positive whole number where  $N \leq D$

Exclusion: A positive whole number.

Complete the following information:

\* Numerator: 0      \* Denominator: 0      \* Exclusion: 0

Previous      Next      Save      Cancel

The following details other requirements of this screen:

- Please enter a numerator, 0 is acceptable if that was reported by the EHR technology.
- Numerator must be a whole number.
- Please enter a denominator, 0 is acceptable if there is no measure population.
- Denominator must be a whole number.
- The numerator should be less than or equal to the denominator.
- Exclusion must be a whole number.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

## 10.27 Clinical Core Quality Measure 4 Screen

### Ischemic stroke : Anticoagulation for A-fib/flutter

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your certified EHR reporting for the EHR reporting period even if the report states zero.

Clinical Quality Measures (Year 3 Attestation)

Home  
Reports  
Meaningful Use Questionnaire  
Meaningful Use Menu Options  
Meaningful Use Core Measures  
Meaningful Use Menu Measures  
Clinical Quality Measures  
Pre-Attestation Measure Summary  
View All Payment Years  
Issues/Concerns  
Appeals  
Additional Resources  
User Manual  
Send E-mail

**Questionnaire 4 of 15**

(\*) Red asterisk indicates a required field.

NQF 0436, Stroke-3

Title: Ischemic stroke : Anticoagulation for A-fib/flutter

Denominator = a positive whole number

Numerator = a positive whole number where  $N \leq D$

Exclusion: A positive whole number.

Complete the following information:

\* Numerator 0 \* Denominator 0 \* Exclusions 0

Previous Next Save Cancel

The following details other requirements of this screen:

- Please enter a numerator, 0 is acceptable if that was reported by the EHR technology.
- Numerator must be a whole number.
- Please enter a denominator, 0 is acceptable if there is no measure population.
- Denominator must be a whole number.
- The numerator should be less than or equal to the denominator.
- Exclusion must be a whole number.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

## 10.28 Core Clinical Quality Measure 5 Screen

### Ischemic stroke : Thrombolytic therapy for patients arriving within 2 hours of symptom onset

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your certified EHR reporting for the EHR reporting period even if the report states zero.

Clinical Quality Measures (Year 3 Attestation)

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Appeals  
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**Questionnaire 5 of 15**

(\*) Red asterisk indicates a required field.

NQF 0437, Stroke-4

Title: Ischemic stroke : Thrombolytic therapy for patients arriving within 2 hours of symptom onset

Denominator = a positive whole number

Numerator = a positive whole number where  $N \leq D$

Exclusion: A positive whole number.

Complete the following information:

\* Numerator: 5      \* Denominator: 5      \* Exclusion: 5

Previous      Next      Save      Cancel

The following details other requirements of this screen:

- Please enter a numerator, 0 is acceptable if that was reported by the EHR technology.
- Numerator must be a whole number.
- Please enter a denominator, 0 is acceptable if there is no measure population.
- Denominator must be a whole number.
- The numerator should be less than or equal to the denominator.
- Exclusion must be a whole number.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

## 10.29 Core Clinical Quality Measure 6 Screen

### Ischemic or hemorrhagic stroke : Antithrombotic therapy by day 2

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your certified EHR reporting for the EHR reporting period even if the report states zero.

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Additional Resources  
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**Questionnaire 6 of 15**

(\*) Red asterisk indicates a required field.

NQF 0438 ,Stroke-5

Title: Ischemic or hemorrhagic stroke : Antithrombotic therapy by day 2

Denominator = a positive whole number

Numerator = a positive whole number where  $N \leq D$

Exclusion: A positive whole number.

Complete the following information:

\* Numerator: 6 \* Denominator: 6 \* Exclusion: 6

Previous Next Save Cancel

The following details other requirements of this screen:

- Please enter a numerator, 0 is acceptable if that was reported by the EHR technology.
- Numerator must be a whole number.
- Please enter a denominator, 0 is acceptable if there is no measure population.
- Denominator must be a whole number.
- The numerator should be less than or equal to the denominator.
- Exclusion must be a whole number.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.



## 10.30 Core Clinical Quality Measure 7 Screen

### Ischemic stroke :Discharge on statins

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your certified EHR reporting for the EHR reporting period even if the report states zero.

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User Manual  
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**Questionnaire 7 of 15**

(\*) Red asterisk indicates a required field.

NQF 0439, Stroke-6

Title: Ischemic stroke:Discharge on statins

Denominator = a positive whole number

Numerator = a positive whole number where  $N \leq D$

Exclusion: A positive whole number.

Complete the following information:

\* Numerator: 7      \* Denominator: 7      \* Exclusion: 7

Previous      Next      Save      Cancel

The following details other requirements of this screen:

- Please enter a numerator, 0 is acceptable if that was reported by the EHR technology.
- Numerator must be a whole number.
- Please enter a denominator, 0 is acceptable if there is no measure population.
- Denominator must be a whole number.
- The numerator should be less than or equal to the denominator.
- Exclusion must be a whole number.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

## 10.31 Core Clinical Quality Measure 8 Screen

### Ischemic or hemorrhagic stroke :Stroke Education

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your certified EHR reporting for the EHR reporting period even if the report states zero.

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**Questionnaire 8 of 15**

(\*) Red asterisk indicates a required field.

NQF 0440 ,Stroke-8  
Title: Ischemic or hemorrhagic stroke :Stroke Education  
Denominator = a positive whole number  
Numerator = a positive whole number where  $N \leq D$   
Exclusion: A positive whole number.  
Complete the following information:

\* Numerator :8 \* Denominator :8 \* Exclusion :8

Previous Next Save Cancel

The following details other requirements of this screen:

- Please enter a numerator, 0 is acceptable if that was reported by the EHR technology.
- Numerator must be a whole number.
- Please enter a denominator, 0 is acceptable if there is no measure population.
- Denominator must be a whole number.
- The numerator should be less than or equal to the denominator.
- Exclusion must be a whole number.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

## 10.32 Core Clinical Quality Measure 9 Screen

### Ischemic or hemorrhagic stroke: Rehabilitation assessment

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your certified EHR reporting for the EHR reporting period even if the report states zero.

Clinical Quality Measures (Year 3 Attestation)

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**Questionnaire 9 of 15**

(\*) Red asterisk indicates a required field.

NQF 0441, Stroke-10

Title: Ischemic or hemorrhagic stroke :Rehabilitation assessment

Denominator = a positive whole number

Numerator = a positive whole number where  $N \leq D$

Exclusion: A positive whole number.

Complete the following information:

\* Numerator: 9      \* Denominator: 9      \* Exclusion: 9

Previous      Next      Save      Cancel

The following details other requirements of this screen:

- Please enter a numerator, 0 is acceptable if that was reported by the EHR technology.
- Numerator must be a whole number.
- Please enter a denominator, 0 is acceptable if there is no measure population.
- Denominator must be a whole number.
- The numerator should be less than or equal to the denominator.
- Exclusion must be a whole number.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

## 10.33 Core Clinical Quality Measure 10 Screen

### VTE prophylaxis within 24 hours of arrival

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your certified EHR reporting for the EHR reporting period even if the report states zero.

Clinical Quality Measures (Year 3 Attestation)

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**Questionnaire 10 of 15**

(\*) Red asterisk indicates a required field.

NQF 0371, VTE - 1

Title: VTE prophylaxis within 24 hours of arrival

Denominator = a positive whole number

Numerator = a positive whole number where  $N \leq D$

Exclusion: A positive whole number.

Complete the following information:

\* Numerator: 10      \* Denominator: 10      \* Exclusion: 10

Previous      Next      Save      Cancel

The following details other requirements of this screen:

- Please enter a numerator, 0 is acceptable if that was reported by the EHR technology.
- Numerator must be a whole number.
- Please enter a denominator, 0 is acceptable if there is no measure population.
- Denominator must be a whole number.
- The numerator should be less than or equal to the denominator.
- Exclusion must be a whole number.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

## 10.34 Core Clinical Quality Measure 11 Screen

### Intensive Care Unit VTE prophylaxis

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your certified EHR reporting for the EHR reporting period even if the report states zero.

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**Questionnaire 11 of 15**

(\*) Red asterisk indicates a required field.

NQF 0372, VTE - 2

Title: Intensive Care Unit VTE prophylaxis

Denominator = a positive whole number

Numerator = a positive whole number where  $N \leq D$

Exclusion: A positive whole number.

Complete the following information:

\* Numerator: 11      \* Denominator: 11      \* Exclusion: 11

Previous      Next      Save      Cancel

The following details other requirements of this screen:

- Please enter a numerator, 0 is acceptable if that was reported by the EHR technology.
- Numerator must be a whole number.
- Please enter a denominator, 0 is acceptable if there is no measure population.
- Denominator must be a whole number.
- The numerator should be less than or equal to the denominator.
- Exclusion must be a whole number.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

## 10.35 Core Clinical Quality Measure 12 Screen

### Anticoagulation overlap therapy

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your certified EHR reporting for the EHR reporting period even if the report states zero.

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**Questionnaire 12 of 15**

(\*) Red asterisk indicates a required field.

NQF 0373, VTE - 3

Title: Anticoagulation overlap therapy

Denominator = a positive whole number

Numerator = a positive whole number where  $N \leq D$

Exclusion: A positive whole number.

Complete the following information:

\* Numerator: 12      \* Denominator: 12      \* Exclusion: 12

Previous      Next      Save      Cancel

The following details other requirements of this screen:

- Please enter a numerator, 0 is acceptable if that was reported by the EHR technology.
- Numerator must be a whole number.
- Please enter a denominator, 0 is acceptable if there is no measure population.
- Denominator must be a whole number.
- The numerator should be less than or equal to the denominator.
- Exclusion must be a whole number.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

## 10.36 Core Clinical Quality Measure 13 Screen

### Platelet monitoring on unfractionated heparin

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your certified EHR reporting for the EHR reporting period even if the report states zero.

Clinical Quality Measures (Year 3 Attestation)

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**Questionnaire 13 of 15**

(\*) Red asterisk indicates a required field.

NQF 0374, VTE - 4

Title: Platelet monitoring on unfractionated heparin

Denominator = a positive whole number

Numerator = a positive whole number where  $N \leq D$

Exclusion: A positive whole number.

Complete the following information:

\* Numerator: 13      \* Denominator: 13      \* Exclusion: 13

Previous      Next      Save      Cancel

The following details other requirements of this screen:

- Please enter a numerator, 0 is acceptable if that was reported by the EHR technology.
- Numerator must be a whole number.
- Please enter a denominator, 0 is acceptable if there is no measure population.
- Denominator must be a whole number.
- The numerator should be less than or equal to the denominator.
- Exclusion must be a whole number.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

## 10.37 Core Clinical Quality Measure 14 Screen

### VTE discharge instructions

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your certified EHR reporting for the EHR reporting period even if the report states zero.

Clinical Quality Measures (Year 3 Attestation)

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**Questionnaire 14 of 15**

(\* ) Red asterisk indicates a required field.

NQF 0375, VTE - S

Title: VTE discharge instructions

Denominator = a positive whole number

Numerator = a positive whole number where N <= D

Exclusion: A positive whole number.

Complete the following information:

\* Numerator 14 \* Denominator 14 \* Exclusion 14

Previous Next Save Cancel

The following details other requirements of this screen:

- Please enter a numerator, 0 is acceptable if that was reported by the EHR technology.
- Numerator must be a whole number.
- Please enter a denominator, 0 is acceptable if there is no measure population.
- Denominator must be a whole number.
- The numerator should be less than or equal to the denominator.
- Exclusion must be a whole number.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.



## 10.38 Core Clinical Quality Measure 15 Screen

### Incidence of potentially preventable VTE

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your certified EHR reporting for the EHR reporting period even if the report states zero.

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**KENTUCKY**  
CABINET FOR HEALTH AND FAMILY SERVICES  
KY MEDICAID EHR INCENTIVE PAYMENTS

Clinical Quality Measures (Year 3 Attestation)

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**Questionnaire 15 of 15**

(\*) Red asterisk indicates a required field.

NQF 0376, VTE - 6

Title: Incidence of potentially preventable VTE

Denominator = a positive whole number

Numerator = a positive whole number where N <= D

Exclusion: A positive whole number.

Complete the following information:

\* Numerator 15 \* Denominator 15 \* Exclusion 15

Previous Next Save Cancel

The following details other requirements of this screen:

- Please enter a numerator, 0 is acceptable if that was reported by the EHR technology.
- Numerator must be a whole number.
- Please enter a denominator, 0 is acceptable if there is no measure population.
- Denominator must be a whole number.
- The numerator should be less than or equal to the denominator.
- Exclusion must be a whole number.

Please note that selecting 'Previous' prior to saving will result in the data on the current screen not being saved. If the user clicks on 'Next', data entered on the screen will also be saved.

## 10.39 Meaningful Use Summary of Measure Screen

**Meaningful Use Core Measures Summary** – Takes the EH to a summary screen of their entries for the Core MU measures. This screen will allow them to edit any entry they have made prior to continuing with their attestation.

**Meaningful Use Menu Measures Summary** – Takes the EH to a summary screen of their entries for the Menu MU measures. This screen will allow them to edit any entry they have made prior to continuing with their attestation.

**Clinical Quality Measures Summary** – Takes the EH to a summary screen of their entries for the Clinical Quality measures. This screen will allow them to edit any entry they have made prior to continuing with their attestation.

Summary of Measures (Year 3 Attestation)

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**Summary of Measures**

Please select the desired measure link below to review the details of your attestation. This is your last chance to view/edit the information you have entered before you attest. Please review your information as you will be unable to edit your information after you attest.

[Meaningful Use Core Measures Summary](#)

[Meaningful Use Menu Measures Summary](#)

[Clinical Quality Measures Summary](#)

Previous Next

### Navigation:

**Logout Button** – Returns the EH to the login page

**Meaningful Use Core Measures Link** – Takes the EH to the summary screen for Meaningful Use Core Measures

**Meaningful Use Menu Measures Link** - Takes the EH to the summary for Meaningful Use Menu Measures

**Core Clinical Quality Measures Link** – Takes the EH to the Summary of all Clinical Quality Measures

**Previous** – Takes the EH to the Additional Clinical Quality Measures screen

**Next** – Takes the EH to the Incentive Payment Calculations screen

## 10.40 Meaningful Use Core Measures Summary Screen

This screen lists the Objective, Measure and Data entered by the EH for each Core Meaningful Use Measure. The EH may click on Edit on a measure row to return to that Measure and update their entry.

Summary of Meaningful Use Core Measures (Year 3 Attestation)				
<a href="#">Home</a> <a href="#">Reports</a> <a href="#">Meaningful Use Questionnaire</a> <a href="#">Meaningful Use Menu Options</a> <a href="#">Meaningful Use Core Measures</a> <a href="#">Clinical Quality Measures</a> <a href="#">Year 3 Attestation Measure Summary</a> <a href="#">View All Payment Years</a> <a href="#">Issues/Comments</a> <a href="#">Appendix</a> <a href="#">Additional Resources</a> <a href="#">User Manual</a> <a href="#">Send E-mail</a>	Meaningful Use Core Measure List Table			
	Please select the edit link next to the measure you wish to update. If you do not wish to edit your measures you may select next to continue.			
	ObjectiveText	Description	Data Entered	Selection
	Use Computerized Provider Order Entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.	More than 30% of medication orders created by the authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.	Numerator = 1000 Denominator = 1200	<a href="#">Edit</a>
	Implement drug-drug and drug-allergy interaction checks.	The eligible hospital or CAH has enabled this functionality for the entire EHR reporting period.	Yes	<a href="#">Edit</a>
	Maintain an up-to-date problem list of current and active diagnoses.	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as structured data.	Numerator = 2 Denominator = 2	<a href="#">Edit</a>
	Maintain active medication list.	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.	Numerator = 3 Denominator = 3	<a href="#">Edit</a>
	Maintain active medication allergy list.	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.	Numerator = 4 Denominator = 4	<a href="#">Edit</a>
	Record all of the following demographics: <ul style="list-style-type: none"> <li>• Preferred language</li> <li>• Gender</li> <li>• Race</li> <li>• Ethnicity</li> <li>• Date of birth</li> <li>• And preliminary cause of death in the event of mortality in the hospital or CAH.</li> </ul>	More than 50% of all unique patients seen by the eligible hospital or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data.	Numerator = 6 Denominator = 6	<a href="#">Edit</a>
	Record and chart changes in vital signs: <ul style="list-style-type: none"> <li>• Height</li> <li>• Weight</li> <li>• Blood pressure</li> <li>• Calculate and display body mass index (BMI)</li> <li>• Plot and display growth charts for children 2-20 years, including BMI.</li> </ul>	More than 50% of all unique patients admitted by the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data.	Numerator = 7 Denominator = 7	<a href="#">Edit</a>
	Record smoking status for patients 13 years old or older	More than 50% of all unique patients 13 years old or older admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data.	Numerator = 7 Denominator = 7	<a href="#">Edit</a>
	Implement one clinical decision support rule related to a high priority hospital condition along with the ability to track compliance to that rule.	Implement one clinical decision support rule	Yes	<a href="#">Edit</a>
	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, discharge summary, procedures), upon request	More than 50% of all patients of the inpatient or emergency department of the eligible hospital or CAH (POS 21 or 23) who request an electronic copy of their health information are provided it within 3 business days.	Numerator = 1 Denominator = 1	<a href="#">Edit</a>
	Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request.	More than 50% of all patients who are discharged from an eligible hospital or CAH's inpatient department or emergency department (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided it.	Numerator = 1 Denominator = 1	<a href="#">Edit</a>
	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.	Yes	<a href="#">Edit</a>
<div> <a href="#">Previous</a> <a href="#">Next</a> </div>				

### Navigation:

**Logout Button** – Returns the EH to the login page

**Previous** – Takes the EH to the Summary of Measures screen

**Next** – Takes the EH to the Incentive Payment Calculations screen

## 10.41 Meaningful Use Menu Measures Screen

This screen lists the Objective, Measure and Data entered by the EH for each Menu Meaningful Use Measure. The EH may click on Edit on a measure row to return to that Measure and update their entry.

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[Meaningful Use Menu Measures](#)  
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Summary of Meaningful Use Menu Measures (Year 3 Attestation)

**Meaningful Use Menu Measure List Table**  
Please select the edit link next to the measure you wish to update. If you do not wish to edit your measures you may select next to continue.

Object	Measure	Entered	Selection
Generate lists of patients by specific conditions to use for quality improvements, reduction of disparities, or outreach.	Generate at least one report listing patients of the eligible hospital or CAH with a specific condition.	Yes	<a href="#">Edit</a>
Use certified EHR technology to identify patientspecific education resources and provide those resources to the patient if appropriate.	More than 10 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are provided patient-specific education resources.	Numerator = 20 Denominator = 20	<a href="#">Edit</a>
The eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	The eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23).	Numerator = 50 Denominator = 50	<a href="#">Edit</a>
The eligible hospital or CAH that transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral.	The eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals.	Numerator = 50 Denominator = 50	<a href="#">Edit</a>
Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice except where prohibited.	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an eligible hospital or CAH submits such information have the capacity to receive the information electronically).	Yes	<a href="#">Edit</a>

Previous

Next

### Navigation:

**Logout Button** – Returns the EH to the login page

**Previous** – Takes the EH to the Summary of Measures screen

**Next** – Takes the EH to the Incentive Payment Calculations screen

## 10.42 Summary of Clinical Quality Measures (CQM) Screen

This screen lists the Objective, Measure and Data entered by the EH for each Menu Meaningful Use Measure. The EH may click on Edit on a measure row to return to that Measure and update their entry.

Summary of Clinical Quality Measures (Year 3 Attestation)				
Please select the edit link next to the measure you wish to update. If you do not wish to edit your measures you may select next to continue.				
<b>Core Clinical Quality Measure List Table</b>				
Measure#	Title	Measure	Data Entered	Selection
NQF 0435	Emergency Department Throughput - admitted patients Median time from ED arrival to ED departure for admitted patients	Emergency Department (ED)-1	Denominator = 1 Numerator = 1 Exclusion = 1	<a href="#">Edit</a>
NQF 0437	Emergency Department Throughput - admitted patients Admission decision time to ED departure time for admitted patients	Emergency Department (ED)-2	Denominator = 2 Numerator = 2 Exclusion = 2	<a href="#">Edit</a>
NQF 0441	Ischemic or hemorrhagic stroke: Rehabilitation assessment	Stroke-10	Denominator = 9 Numerator = 9 Exclusion = 9	<a href="#">Edit</a>
NQF 0435	Ischemic stroke : Discharge on anti-thrombotics	Stroke-2	Denominator = 0 Numerator = 0 Exclusion = 0	<a href="#">Edit</a>
NQF 0436	Ischemic stroke : Anticoagulation for A-fib/flutter	Stroke-3	Denominator = 0 Numerator = 0 Exclusion = 0	<a href="#">Edit</a>
NQF 0437	Ischemic stroke : Thrombolytic therapy for patients arriving within 2 hours of symptom onset	Stroke-4	Denominator = 5 Numerator = 5 Exclusion = 5	<a href="#">Edit</a>
NQF 0438	Ischemic or hemorrhagic stroke : Antithrombotic therapy by day 2	Stroke-5	Denominator = 6 Numerator = 6 Exclusion = 6	<a href="#">Edit</a>
NQF 0438	Ischemic stroke :Discharge on statins	Stroke-6	Denominator = 7 Numerator = 7 Exclusion = 7	<a href="#">Edit</a>
NQF 0440	Ischemic or hemorrhagic stroke :Stroke Education	Stroke-8	Denominator = 8 Numerator = 8 Exclusion = 8	<a href="#">Edit</a>
NQF 0371	VTE prophylaxis within 24 hours of arrival	VTE - 1	Denominator = 10 Numerator = 10 Exclusion = 10	<a href="#">Edit</a>
NQF 0372	Intensive Care Unit VTE prophylaxis	VTE - 2	Denominator = 11 Numerator = 11 Exclusion = 11	<a href="#">Edit</a>
NQF 0373	Anticoagulation overlap therapy	VTE - 3	Denominator = 12 Numerator = 12 Exclusion = 12	<a href="#">Edit</a>
NQF 0374	Platelet monitoring on unfractionated heparin	VTE - 4	Denominator = 13 Numerator = 13 Exclusion = 13	<a href="#">Edit</a>
NQF 0375	VTE discharge instructions	VTE - 5	Denominator = 14 Numerator = 14 Exclusion = 14	<a href="#">Edit</a>
NQF 0376	Incidence of potentially preventable VTE	VTE - 6	Denominator = 15 Numerator = 15 Exclusion = 15	<a href="#">Edit</a>

[Previous](#)
[Next](#)

### Navigation:

**Logout Button** – Returns the EH to the login page

**Previous** – Takes the EH to the Summary of Measures screen

**Next** – Takes the EH to the Incentive Payment Calculations screen

### 10.43 Measure Editing prior to Attestation

The EH may update any field on the measure that they have previously entered. The field editing for the measure will still apply upon the EH clicking save.

**Clinical Quality Measures (Year 3 Attestation)**

Home  
Reports  
Meaningful Use Questionnaire  
Meaningful Use Menu Options  
Meaningful Use Core Measures  
Meaningful Use Menu Measures  
Clinical Quality Measures  
Pre-Attestation Measure Summary  
View All Payment Years  
Issues/Concerns  
Appeals  
Additional Resources  
User Manual  
Send E-mail

**Questionnaire 3 of 15**

(\*) Red asterisk indicates a required field.

NQF 0435, Stroke-2

Title: Ischemic stroke : Discharge on anti-thrombotics

Denominator = a positive whole number

Numerator = a positive whole number where  $N \leq D$

Exclusion: A positive whole number.

Complete the following information:

\* Numerator: 0      \* Denominator: 0      \* Exclusion: 0

Previous      Next      Save      Cancel

#### Navigation

**Logout Button** – Returns the EH to the login page

**Save Button** – Saves the data once all applicable edits are resolved.

**Return to Summary Button** – Takes the EH back to the Measure Summary selection page.



## 10.44 Incentive Payment Calculation Screen

The screen lists the estimated payment for the EH or CAH for the current attestation.

Incentive Payment Calculations (Year 3 Attestation)
Logout

[Home](#)  
[Reports](#)  
[Meaningful Use Questionnaire](#)  
[Meaningful Use Menu Options](#)  
[Meaningful Use Core Measures](#)  
[Meaningful Use Menu Measures](#)  
[Clinical Quality Measures](#)  
[Pre-Attestation Measure Summary](#)  
[View All Payment Years](#)  
[Issues/Concerns](#)  
[Appeals](#)  
[Additional Resources](#)  
[User Manual](#)  
[Send E-mail](#)

Patient Volume Calculations

Medicaid Patient Volume Percentage:	72.07% * should be greater than 10% to qualify
Rate of growth prior year:	-29.730%
Rate of growth 2 years prior:	-3.478%
Rate of growth 3 years prior:	-92.426%
Average rate of growth:	-41.878% * use this growth rate to project number of discharges for year 2 through year 4 below

EHR Amount Calculations

	<u>Year</u>	<u>Discharges</u>	<u>Allowable Discharges</u>	<u>Discharge Related Amount</u>	<u>Base Amount</u>	<u>Aggregate EHR amount</u>	<u>Transition Factor</u>	<u>EHR Amount</u>
First year		234	0	\$0.00	\$2,000,000	\$2,000,000.00	1.00	\$2,000,000.00
Second Year		136	0	\$0.00	\$2,000,000	\$2,000,000.00	.75	\$1,500,000.00
Third Year		79	0	\$0.00	\$2,000,000	\$2,000,000.00	.50	\$1,000,000.00
Fourth Year		46	0	\$0.00	\$2,000,000	\$2,000,000.00	.25	\$500,000.00
<b>Total Amount</b>								<b>\$5,000,000.00</b>

Medicaid Share Calculations

Total Medicaid and Passport Inpatient Bed Days:	18388
Total Bed Days:	155000
Percentage of total charges which are non-charity: ((total charges - uncompensated charges)/ total charges)	100.00%
Total Beds that should be considered non charity:	155000
Total Medicaid Percentage:	11.86323%
Total Medicaid Aggregate EHR Incentive Payment:	\$593,161.29
Total Estimated Medicaid Aggregate EHR Incentive Payment for Year 3 (10%):	\$59,316.13 (This amount may also include adjustments)

Previous

Next

### Navigation

**Logout Button** – Returns the EH to the login page

**Previous** – Return the EH to the Summary of Measures screen

**Next** – Takes the EH to the Document Upload screen

## 10.45 Documentation Upload Screen

Documentation is required to support attestation review and verification. This page will allow the EH to attach documentation with their current year attestation.

- Clicking on the browse button will allow the EH to search and select the documents they would like to attach.
- Clicking on the upload button will attach and save the document relating to the current attestation payment year.
- Only PDFs that are below 100MB can be uploaded.

Please Note: Documentation loaded with the attestation does not alleviate the provider from being requested to produce additional documentation that may be requested during a pre-payment or post payment audit. All documentation supporting the information attested by the Provider or Facility should be kept for 6 years.

Document Upload (Year 3 Attestation) Logout

Home  
Reports  
Meaningful Use Questionnaire  
Meaningful Use Menu Options  
Meaningful Use Core Measures  
Meaningful Use Menu Measures  
Clinical Quality Measures  
Pre-Attestation Measure Summary  
View All Payment Years  
Issues/Concerns  
Appeals  
Additional Resources  
User Manual  
Send E-mail

Documentation needed to process your application may be attached below. If you cannot attach a PDF then use the Send E-mail link on the left to contact the EHR staff for assistance. Please provide proof of certified technology being attested for your practice or facility. This can be a contract, invoice, purchase order, etc. If you are attesting to Meaningful Use Measures, please provide documentation on your testing with other entities as well as documentation supporting your Public Health Measure response. Patient Volume documentation is not required but if you are using Medicaid patients from multiple states you could be requested to provide additional documentation. Please Note: Documentation loaded with the attestation does not alleviate the provider from being requested to produce additional documentation that may be requested during a pre payment or post payment audit. All documentation supporting the information attested by the Provider or Facility should be kept for 6 years.

Payment Year	File Name	Description
No uploaded document found.		

Upload a new PDF document:

Please select the documentation type:

If you cannot attach a PDF, then use the Send E-mail link on the left side of the screen to contact the EHR staff for assistance. Please provide proof of certified technology being attested for your practice or facility. This can be a contract, invoice, purchase order, etc.

If you are attesting to Meaningful Use Measures, please provide documentation on your testing with other entities as well as documentation supporting your Public Health Measure response. Patient Volume documentation is not required but if you are using Medicaid patients from multiple states you could be requested to provide additional documentation.



## 10.46 Attestation Statement Screen

The EH must check all checkboxes and enter their initials and NPI in order to submit their attestation. After initials and NPI are entered, click on the “Submit” to complete your attestation.

Attestation Statement (Year 3 Attestation)

[Home](#)  
[Reports](#)  
[Meaningful Use Questionnaire](#)  
[Meaningful Use Menu Options](#)  
[Meaningful Use Core Measures](#)  
[Meaningful Use Menu Measures](#)  
[Clinical Quality Measures](#)  
[Pre-Attestation Measure Summary](#)  
[View All Payment Years](#)  
[Issues/Concerns](#)  
[Appeals](#)  
[Additional Resources](#)  
[User Manual](#)  
[Send E-mail](#)

### Attestation Statements

**You are about to submit your attestation for EHR.**

Please check the box next to each statement below to attest, then select the SUBMIT button to complete your attestation:

☐ The information submitted for CQMs was generated as output from an identified certified EHR technology.

☐ The information submitted is accurate to the knowledge and belief of the official submitting on behalf of the eligible hospital or CAH.

☐ The information submitted is accurate and complete for numerators, denominators, and exclusions for functional measures that are applicable to the Hospital or CAH.

☐ The information submitted includes information on all patients to whom the measure applies.

☐ For CQMs, A zero was reported in the denominator of a measure when an eligible hospital or CAH did not care for any patients in the denominator population during the EHR reporting period.

I understand that I must have, and retain, documentation to support my eligibility for incentive payments and that the Department for Medicaid Services may ask for this documentation. I further understand that the Department for Medicaid Services will pursue repayment in all instances of improper or duplicate payment. I certify I am not receiving Medicaid EHR incentive funds from any other state or commonwealth and have not received a payment from the Kentucky Department for Medicaid Services for this year.

This is to certify that the foregoing information is true, accurate, and complete. I understand the Medicaid EHR incentive payments submitted under this provider number will be from Federal funds, and that any falsification, or concealment of a material fact may be prosecuted under Federal and State laws.

**All \* fields are required fields.**

Initials: \*   
 NPI: \*

**Note: Once you press the submit button below, you will not be able to change your information.**

## 10.47 Accepted Attestation Screen

The EH can view their measure summaries for all measure entries. The attestation will be sent for internal review and final approval for payment.

Attestation Summary Menu (Year 2 Attestation)

[Home](#)  
[Meaningful Use Questionnaire](#)  
[Meaningful Use Menu Options](#)  
[Meaningful Use Core Measures](#)  
[Meaningful Use Menu Measures](#)  
[Clinical Quality Measures](#)  
[Alternate Clinical Quality Measures](#)  
[Additional Clinical Quality Measures](#)  
[Pre-Attestation Measure Summary](#)  
[Post-Attestation Measure Summary](#)  
[View All Payment Years](#)  
[Issues/Concerns](#)  
[Appeals](#)  
[Additional Resources](#)  
[User Manual](#)  
[Send E-mail](#)

Your attestation has been accepted.

All measures and their corresponding calculation have met compliance. Please select the desired measure link below to view the details of your submitted measures.

[Meaningful Use Core Measures Summary](#)  
[Meaningful Use Menu Measures Summary](#)  
[Clinical Quality Measures Summary](#)

## 10.48 Unaccepted Attestation Screen

If your attestation is not accepted, you can review the summary of measures and look for the indication of which measure(s) were not accepted using the Unaccepted Attestation Screen. To view the summary, select the link for one of the three measures.

The EH will be allowed to re-attest once the EH is able to meet the measure requirements.

Attestation Summary Menu (Year 1 Attestation)

[Home](#)  
[Meaningful Use Questionnaire](#)  
[Meaningful Use Menu Options](#)  
[Meaningful Use Core Measures](#)  
[Meaningful Use Menu Measures](#)  
[Clinical Quality Measures](#)  
[Alternate Clinical Quality Measures](#)  
[Additional Clinical Quality Measures](#)  
[Pre-Attestation Measure Summary](#)  
[View All Payment Years](#)  
[Issues/Concerns](#)  
[Appeals](#)  
[Additional Resources](#) ▶  
[User Manual](#) ▶  
[Send E-mail](#)

Your attestation cannot be accepted at this time.

One or more of the MU Core measure calculations did not meet MU minimum standards.  
 One or more of the MU menu measures did not meet MU minimum standards.

Please select the summary of measures link below to view all measures and their corresponding calculation/compliance.

[Meaningful Use Core Measures Summary](#)  
  
[Meaningful Use Menu Measures Summary](#)  
  
[Clinical Quality Measures Summary](#)

## 10.49 View All Payments Screen

The payments screen allows the user to view previous payments including the payment year, amount, date and type. To access the screen, click on the Payment link in the menu on the left side of the screen. This screen is a read only screen that displays any payments or adjustments made to the EH by payment year.

Payments (Year 3 Attestation)						
<a href="#">Home</a> <a href="#">Reports</a> <a href="#">View All Payment Years</a> <a href="#">Issues/Concerns</a> <a href="#">Appeals</a> <a href="#">Additional Resources</a> ▶ <a href="#">User Manual</a> ▶ <a href="#">Send E-mail</a>	Payments Details:					
	NPI	Payment Year	Payment Amount	Payment Date	Adjustment Amount	Adjustment Date
	011111111	1	21,250.00	1/2/2010	-500.00	1/1/2011
	011111111	1	21,250.00	1/2/2010	-6,000.00	1/18/2012
	011111111	1	21,250.00	1/2/2010	600.00	7/18/2012
	011111111	1	21,250.00	1/2/2010	100.00	10/19/2012
	011111111	1	21,250.00	1/2/2010	-100,000.00	12/10/2012
	011111111	1	21,250.00	1/2/2010	2.00	1/18/2013

## 10.50 Issues / Concerns Screen

The EH may also view and submit issues or concerns by selecting the Issues/Concerns link in the menu on the left side of the screen. The screen:

- 1) Displays previous issues and concerns.
- 2) Allows the user to view previous issues and concerns
- 3) Allows user to view responses to issues and concerns.
- 4) Allows user to submit additional issues or concerns.

To submit Issue/Concerns, select an issue category from the dropdown list and enter the details of their issue or concern. The issue or concern will be saved and submitted the EHR staff upon clicking the submit button.

**KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES**  
KY MEDICAID EHR INCENTIVE PAYMENTS

Issues/Concerns Logout

If you have any issue with the determination of your incentive payment application including but not limited to Eligibility, Patient volume or Payment Amount, you can notify us using the form below. Please be further advised that you also have access to a formal appeal process.

**Issues/Concerns List:**

View Issue	Date Entered	Issue/Concern Status	Issue/Concern Description	Issue Category	
Select	2/15/2011 4:55:40 PM	Open	Am I eligible for th...	Eligibility	Delete

**Resolved Issues/Concerns List:**

	Issue/Concern Response	Responded By	Date Responded	Issue/Concern Status	Issue Category
Select	Payment done! please...	harika.reddy	2/15/2011 4:53:43 PM	Resolved	Payment Amount
Select	That's good.	harika.reddy	2/15/2011 4:54:32 PM	Resolved	Patient Volume

**Enter the issue/Concern below:**

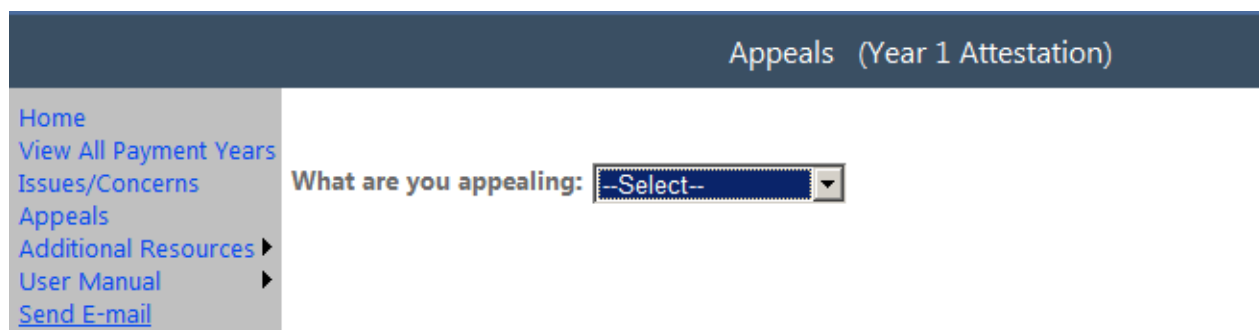
Issue Category: --Select the category below--

Description:

The EH may submit an issue or concern by selecting an issue category and typing in the details of their issue or concern. It will be saved upon them clicking the submit button.

## 11 AUDIT AND APPEALS

This section of the User manual includes information about features that are available to the provide from the Appeals link in the menu on the left side of the screen.



Upon selecting the “Appeals” Link from the menu on the left, the user will be given a dropdown menu to select from.

- Clicking on the Attestation Appeal option will direct the EH to a screen that will detail the process of submitting a formal letter of appeal.
- Clicking on the Audit Appeals Process will direct the EH to a screen that will show an audit grid displaying the status of any audits.

### 11.1 Attestation Appeals Screen

The Appeals screen informs the EH of how to initiate an appeal and provides contact information for the appeal.



## 11.2 Appeals Screen – Provider Audit Appeal

If there are any audits, the user may view audit information by selecting the audit using the Select link in the row for the audit grid.

Appeals (Year 2 Attestation)

Home  
View All Payment Years  
Issues/Concerns  
Appeals  
Additional Resources  
User Manual  
Send E-mail

What are you appealing: Audit Appeal

**Provider Audit Appeal**

Name	NPI	Payee NPI	CCN	Status	Start date	Program Year	Select
TEST TEST	1122112211	1122112211		Audit Completed	4/10/2013	2012	<a href="#">Select</a>

## 11.3 Audit Appeal Details Screen Appeal Setup Tab

If the EH would like to appeal the audit, the select Audit Appeal option from the dropdown. Select the audit to be appealed using the select button. After the provider selects the audit, screen is displayed providing a summary of the audit including case number, name, and other identifying information. The screen also displays information about the audit including status, view appeals, review findings, any appeals document that have been uploaded and view the outcome of an appeal.

(Year 2 Attestation)

Home  
View All Payment Years  
Issues/Concerns  
Appeals  
Additional Resources  
User Manual  
Send E-mail

**Summary**

Audit Case Number:	606060606	Audit Status:	Audit Completed
Name:	TEST TEST	NPI:	1122112211
Payee NPI:	1122112211	Address:	123 test court, st 818, Test, KY, 40001
Audit Program Year:	2012	Audit Payment Year:	1
Appeal Status:	Received filed appeal		

Appeal Setup | Findings | Appeal Document Upload | Appeal Outcome

**Appeal Setup**

Appeal File Date: 4/10/2013

Appeal Reason: Other

Appeal Type: Adopt Implement and Upgrade

Appeal Notes:

Not true  
test

Previous Save Save & Next

### Navigation

**Logout Button** – Returns the EH to the login page

**Previous** – Takes the EH to the Appeals Screen

**Save** – Saves the data and displays the information on the screen above the text box.

**Save and Next** – Save the data and displays the information on the screen above the text box and displays the Findings tab.

To create an appeal, the user will:

- 1) Select the date appeal is to be filed
- 2) Select the type of Appeal from the drop down list.
- 3) Select the type of appeal from the dropdown list.
- 4) Enter any notes related to the appeal as text in the text box. (Maximum of 8,000 characters)

**Appeal Setup**

Appeal File Date: 4/10/2013

Appeal Reason: Other

Appeal Type: Adopt Implement and Upgrade

Appeal Notes: Not true test

Previous Save Save & Next

After the user completes the appeal set-up, the user may save the appeals using the Save or Save & Next buttons.

#### 11.4 Audit Appeal Details Screen Findings Tab

The findings tab provides information about any finding related to the appeal. If there are finding, information will be displayed in the appeals finding grid including start date, end date, notes, and provider comments if any. If the audits indicated that provider action was required, then the box in the grid will have a check.

The provider may submit comments related to an appeal finding. First select the finding if more than one by clicking on the select button for the desired finding.

**Appeal Findings**

	Start Date	End Date	Notes	Provider Comments	Provider Action Required
Select	4/10/2013	4/10/2013	Need more information...		<input checked="" type="checkbox"/>

Findings Notes:

Provider Comments:

Previous Save Save & Next

Enter comments in the text box labeled Provider Comments. After completing the comment click save or save and next. If the user clicks save, the comment will be displayed in the Provider comment grid.

### Navigation:

**Logout Button** – Returns the EH to the login page

**Previous** – Takes the EH to the Appeals Screen

**Save** – Saves the data and displays the information on the screen above the text box.

**Save and Next** – Saves the data and displays the information on the screen above the text box and displays the Appeal Document Upload tab.

## 11.4.1 Audit Appeal Details Screen Appeal Document Upload

This screen is where the EH will upload any documentation related to their audit appeal.

- User will select the “Browse” and then select the document for upload
- From the dropdown menu the user will select the document type
- Upon selection of the Upload button your Appeal information will be submitted and the document information will display in the Document Upload grid.

Note: Documents for upload are limited to PDF format and files size not to exceed 100 MB.

View	Document Name	Document Type	Date Uploaded	
<a href="#">View</a>	EP Documentation.docx	EHR certification documents	4/24/2013 12:48:17 PM	<a href="#">Delete</a>

Upload Document:  [Browse...](#)

Document Type: --Select--

[Previous](#) [Upload](#) [Next](#)

### Navigation:

**Logout Button** – Returns the EH to the login page

**Previous** – Take the EH to the Appeals Screen

**Upload** – Saves the document and displays the information on the document upload grid.

**Next** – Displays the Appeal Outcome tab.

11.4.2 Audit Appeal Details Screen Appeal Outcome Tab

This tab will show the outcome of your appeal and include information or comments relating to your audit.

Appeal Setup

Findings

Appeal Document Upload

Appeal Outcome

Appeal Outcome:

Still not meeting volume

Previous